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RELAXANTS IN ELECTRO-THERAPY; TECHNIQUE AND A COMPARATIVE EVALUATION

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Wide divergencies of psychiatric opinion between one school and another, or indeed between individual psychiatrists, may be interpreted as a sign of the healthy state of psychiatry. It is perhaps less healthy that divergencies should also exist in the field of technique. The increasing use or abuse of electro-convulsive therapy is one of the areas in which considerable confusion exists. This confusion applies not only to the indications, mode of action and effects of this form of treatment, but there are also very wide variations in the technique with which it is applied.

It is common experience that the use of muscle relaxants with electro-convulsive therapy is by no means universal, and that when a relaxant is used, centres differ in opinion both as to the relaxant of choice and as to the most suitable method for its administration.

The paper which follows is an attempt to clarify this position. The attempt is limited to the topic of a comparison between eight relaxants, namely:—

1. D-tubocurarine chloride
2. Gallamine-triethiodide, ("Flaxedil")
3. Decamethomium iodide, ("Syncurine", C-10)
4. Suxamethonium bromide, ("Brevidil M")
5. Suxethonium bromide, ("Brevidil E")
6. Succinylcholine chloride, ("Scoline", "Anectine")
7. 2, 5-bis-(3-diethylaminopropylamino)-benzoquinone-bis-(benzylchloride), ("Mytolon")
8. Laudexium methylsulphate, ("Laudolissin")

A technique of modified electro-convulsive therapy will also be described.

It is relevant to observe that the drugs were used in doses of equal potential by one worker under exactly similar conditions at the Royal Edinburgh Hospital for Mental and Nervous Disorders. It is considered that such work constitutes a valid contribution to the study of E.C.T. technique and modification.

The work is based on the premise which will be discussed later, that the use of a safe relaxant is obligatory in the great majority of cases.

For obvious reasons of clarity and simplicity, questions of diagnostic labelling, psychiatric indications for treatment, and theoretical considerations regarding the mode of action of electro-convulsive therapy are excluded from this paper.

Many publications have appeared describing the use of individual relaxants. Most of these deal with succinylcholine only, and without making comparative studies, are agreed that this drug is the relaxant of choice.

A few limited comparative studies have been made, however. In 1949 Bovet (3) who had introduced gallamine in France, found it less preferable than succinylcholine, since the latter did not induce tachycardia. This observation was supported by Scurr (23) who believed that the tachycardia produced by gallamine might be due to an atropine-like action.

Green and Woods (12) in an E.C.G. study of patients receiving electro-convulsive therapy with succinylcholine reported that sinus tachycardia was usual, and that premature beats occurred in 39% of the cases. The authors did not

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suggest that heart disease was a contra-indication to modified E.C.T., but did recommend that cases in whom the occurrence of cardiac arrythmias was considered possible, quinidine should be used prophylactically. Bovet found that succinylcholine in single doses produced no rise in blood pressure and that it caused no increase in secretions, even without the use of atropine. Copious secretions were produced when instruments were introduced into the mouth and pharynx.

In the same year, 1949, Coffin (4) compared tubocurarine and decamethomium iodide. He favoured the latter relaxant since smaller doses of thiopentone were required to cover the period of paralysis. He never found the use of prostigmine necessary.

On the other hand, Foldes(7) and others believed that the use of succinylcholine required the administration of larger doses of thiopentone than the other relaxants. It is possible that small doses of succinates may produce greater cortical activity when combined with barbiturate anaesthesia. This disadvantage probably does not apply to the use of succinylcholine with electro-convulsive therapy.

Margolis (18) and his co-workers also preferred decamethomium bromide to tubocurarine, which in many cases did not produce optimal relaxation, in others caused respiratory distress, and in still others was followed by pronounced histamine-like reactions. Their review covered a relatively small number of treatments.

The histamine liberating effect of tubocurarine has also been commented upon by Bourne (2) and others, who found that gallamine had only 1/100 the potency of tubocurarine in this respect.

In an attempt to find the relaxant most suitable for the electro-convulsive treatment of patients with concomitant cardiac disease, Holt (16) and others compared the effects on blood pressure, pulse and respiration of gallamine and succinylcholine. Although they found that the latter drug produced more pulse irregularities, they, like Bovet, preferred it to gallamine since its duration of action was shorter, its modification of the convulsion was greater, and its effect upon the patient less distressing.

Moss (21) and others found succinylcholine preferable to tubocurarine, the use of which he considered to be not without danger. His work covered a series of about 300 treatments.

In a comparative study of succinylcholine chloride, suxamethonium bromide, and suxethonium bromide, Monro (19) and others reported two cases of prolonged apnoea when the first of these three drugs was used in a series of 653 treatments. They nevertheless considered it to be the most consistent relaxant of those studied.

Forbat, Lehmann and Silk (8) reported a case of apnoea of 40 minutes duration following the use of succinylcholine in a patient who had a low pseudocholinesterase level (8 units).

That the danger of prolonged apnoea is a real one is emphasized by Saltzman (22) et al. These workers in a large series of 7500 treatments had no cases of prolonged apnoea and yet regarded it as essential that the therapist giving succinylcholine be skilled in the giving of oxygen under positive pressure and in the maintenance of an airway.

The occurrence of prolonged apnoea when succinylcholine has been used has been reported by numerous other workers. In spite of this, most have been agreed that it is the most effective relaxant for use with electro-convulsive therapy, although no wide comparative studies have been made. In particular, succinylcholine has been found to be effective in the prevention of fractures.

Wilson and Nowill (24) in a series of 1045 treatments reported one case of atalectasis, one of aspiration pneumonia, and one of cervical vertebral fracture. Faulty anaesthetic technique was held to be responsible for these three incidents. In the same series, the authors had a case of apnoea of 10 minutes duration, and fractures occurred in two other patients on the occasion of the first unmodified E.C.T. following discontinuance of succinylcholine.

Holmberg and Thesleff (15) also reported one case of fracture in a series of 512 treatments. This they dismiss as insignificant. These authors also reported that many of their patients complained of jaw and calf pains following electro-convulsive therapy modified by succinylcholine.

Relaxants other than succinylcholine have received much less attention in the literature.

Gillie and McNeil (9) in a search for a relaxant which was without danger or discomfort to the patient when used to modify E.C.T. considered that suxethonium bromide was the drug of choice. They had no untoward effects including apnoea or the complications of barbiturate anaesthesia in a series of 1602 treatments. This report was published in 1955.

A most comprehensive report on the relaxants is that carried out by Montagu. (20) He believes that the speed of action, the shortness of effect and the relative absence of untoward side effects of the succinyl compounds renders them the relaxants of choice. Both the Brevidils and Scoline or Anectine are of course included among these compounds, but Montagu does not specify a preference for any one of these three. He holds that the lack of an antidote is to be disregarded since he believes that the occurrence of prolonged apnoea is insufficiently frequent to warrant the need for one. This is not an argument likely to appeal to most workers. It is also unfortunate that Montagu's otherwise excellent review does not include any reference to his own clinical material.

Most of the literature reviewed agrees in placing succinylcholine as the most satisfactory relaxant for the modification of electro-convulsive therapy. The authors concerned have for the most part been content to state the advantages of the drug, without resorting to comparative studies. In addition, techniques remain unstandardized.

The object of this paper is to establish by clinical comparison which of several short acting relaxants is the most useful for the maximum modification of E.C.T. compatible with the safety of the patient regardless of age or the presence of concomitant physical disease. It is also considered necessary that the drug should produce no disturbing after memories of the procedure. The use of a muscle relaxant together with thiopentone involves some expenditure of time. Another requirement therefore, is that a technique be evolved which is practicable under widely differing conditions, and in which the time spent on each treatment is not disproportionately greater than that consumed when E.C.T. is given without modification. This consideration becomes more important when factors such as increasing admission rates to mental hospitals, the increasing popularity of E.C.T., the growing practice of administering this form of treatment in a general hospital, out-patient or private practice setting, and finally the need to train junior physicians to their own and their patients' best advantage are considered. It is relevant to remark here that a technique which reduced the time required for treatment to very low levels was held to be undesirable. Such reduction may tend to increase still further the indiscriminate use of E.C.T.

Technique

The following technique was used throughout the series. It may be subject to certain modification which will be discussed.

The patient receives her usual sedative on the night before treatment. She is given nothing to eat or drink on the morning of treatment. Atropine gr. 1/100 is given on the ward one hour before treatment. Towards the end of this hour, patients are gathered together in groups in a room adjacent to the theatre or other suitable place. Each group consists of those patients who are under the care of an individual physician who is responsible for the administration of treatment to his own patients only. Thus each group of patients is collected at intervals calculated on the basis of 5 minutes per patient. Each patient in turn then walks into the treatment room, and lies supine on the treatment table, preferably a metal trolley. Immediately the patient's breathing is resumed following the giving of treatment, she is wheeled on the same trolley into an ante-room accompanied by her therapist who remains with her until the next patient has arrived in the treatment room and is lying on a second trolley ready to receive her injection and convulsion. The first patient is able to return to her ward in the care of a nurse 10 minutes later. A senior nurse and one assistant remain in the treatment room, another nurse is placed in the ante-room, while two or three others are responsible for the marshalling of patients and their return to wards. Ideally, the treatment rooms should be located at some distance from the wards.

In the case of highly nervous or resistive patients, the thiopentone is administered in the ward in a dosage sufficient to secure anaesthetisation for the period incorporating the journey on a trolley from ward to treatment room and the preconvulsive curarization.

Oxygen cylinders with masks and airways are kept both in the treatment and ante-rooms. The trolley used for treatment is provided with small firm pillows at the head and foot, and with a draw sheet. The patient is covered in such a way that both naked feet are exposed. She is dressed in a garment which produces no constriction, particularly at the waist, chest or neck. She is asked to bite on a rubber gag before receiving her thiopentone. If she wears dentures or glasses, they are removed. Patients are given the opportunity to micturate before appearing for treatment. The patient is not held in any way during treatment.

The thiopentone and curarizing agents are prepared in separate syringes before the treatment session begins. The average dose of thiopentone is 0.25 Gm. (maximum: 0.5 Gm., minimum: 0.075 Gm.) in 2.5% or 5% aqueous solution injected intravenously slowly. The needle is left in situ and the syringe containing the curarizing agent substituted. In the case of succinylcholine this is injected slowly over a period of 20 seconds, and is not started until the effect of the thiopentone is complete. During this period the patient's lungs are inflated with oxygen. The average dosage of succinylcholine is 30 mg. The dosage of other relaxing agents will be mentioned. Uncoordinated small contractions of muscle bundles start about 15 seconds after the injection of succinylcholine and last approximately a further 15 seconds. On completion of these fibrillations the convulsion is immediately given, usually 110 volts for 0.2 seconds. If a relaxant which produces little or no muscle fasciculation is given, then the convulsion is given 30 seconds after the relaxant has been completely administered. Any of the popular machines may be used.

If modification has been optimal the convulsion is seen as periorbital muscular twitching, furrowing of the forehead, extension of the toes or extension of the index finger. At the completion of clonus, the patient is again inflated with oxygen until satisfactory ventilation is resumed. She is then wheeled into the ante-room where the inflation may be continued if necessary. The

next patient is then brought in and prepared on the second trolley. The whole procedure occupies a period of 5 minutes.

Ideally the therapist should be experienced in the giving of oxygen under positive pressure. Failing this, an anaesthetist should perhaps be available. His presence may be useful in the event of endotracheal intubation becoming necessary.

Method

221 female patients were given E.C.T. over an arbitrary period by the author under exactly similar conditions. They received between them a total of 1768 treatments, an average of 8 treatments per patient. A variety of muscle relaxants was used as follows:

1. D-tubocurarine chloride	: 717	treatments
2. Gallamine-tri-ethiodide ("Flaxedil")	: 666	"
3. Decamethomium iodide (C10, "Syncurine")	: 66	"
4. Succinylcholine chloride ("Scoline", "Anectine")	: 159	"
5. "Mytolon"	: 30	"
6. "Laudolissin"	: 10	"
7. No relaxant used	: 120	"

"Myanesin" was also tried but in too few instances for valid comparison.

In addition an attempt was made to give a further group of 25 female patients 6 treatments each using one of 6 different relaxants on each occasion. The 6 relaxants chosen were:

1. Suxethonium bromide ("Brevidil E")	: 16	treatments
2. Suxamethonium bromide ("Brevidil M")	: 25	"
3. D-tubocurarine chloride	: 13	"
4. Gallamine triethiodide ("Flaxedil")	: 18	"
5. Decamethomium iodide (C10, "Syncurine")	: 19	"
6. Succinylcholine chloride ("Scoline", "Anectine")	: 14	"

For a variety of reasons this attempt was not entirely successful and the 25 patients received relaxants as follows:

"Brevidil M" only	: 7	patients
"Brevidil M" and "Flaxedil"	: 2	"
"Brevidil M" and "E" and "Flaxedil"	: 2	"
"Brevidil M" and "E", "Scoline" and "Flaxedil"	: 4	"
All except "Syncurine"	: 4	"
All 6 relaxants	: 9	"

In this group the 25 patients received a total of 95 treatments.

The fact that the study is limited to female patients is due to the fortuitous circumstances that the author was associated with the female wing of the hospital during the arbitrary period covered by the work.

The total of 246 patients involved included a number suffering from concomitant physical disease as follows:

Recent bony injury (pre-treatment	: 2	patients
Recent bony dislocation (pre-treatment)	: 2	"
Recent vertebral fracture (pre-treatment)	: 3	"
Hernia	: 2	"
Severe anaemia	: 1	"
Disseminated sclerosis	: 1	"
Recent confinement	: 2	"
Recent abdominal operation	: 1	"
Hypertension	: 2	"
Mitral stenosis	: 1	"

In addition, 14 patients were aged 60 or over, a further 6 were very emaciated, while 8 had excessive muscular development.

The remaining 201 patients were under 60, without concomitant physical disease or handicap, and were of average development and nutritional state.

All patients, irrespective of age or physical state, were treated equally, except that none of the 45 patients who were over 60 or physically weak or ill or unduly muscular was included among the 120 treatments in which no relaxant was given.

In all treatments the relaxant drugs were given in doses of equal potential. At each treatment blood pressure and pulse readings were taken with the patient supine. This was done just before the injection of thiopentone, immediately after the relaxant had been administered, again just after the completion of clonus and once more 1 minute later when the patient had been inflated with oxygen.

In each case the time from injection of relaxant to first respiratory effort, and to satisfactory ventilation were measured. Nausea, histamine-like effects, headaches, cyanosis and secretions were assessed as being absent ("O"), noticeable ("+") or excessive ("++").

TABLE I

	D-tubocurarine chloride	Gallamine-triethiodide	Decamethonium iodide	Suxethonium bromide	Suxamethonium bromide	Succinylcholine chloride	Mytolon chloride	Laudexium Methylsulphate
Number of treatments	730	684	75	16	25	169	30	10
Dose of relaxant in mg.	15	80	3	75	30	30	15	30
Dose of thiopentone in mg.	25	25	25	25	25	25	25	25
Time in seconds from injection to relaxation	27	20	20	15	17	15	28	31
Range of time in seconds from injection to first respiratory effort	110 to 285	45 to 210	70 to 270	50 to 165	105 to 230	90 to 185	35 to 185	80 to 95
Range of time in seconds from injection to satisfactory ventilation	125 to 315	95 to 780	125 to 330	120 to 280	135 to 260	124 to 305	165 to 300	180 to 840
Range of systolic blood pressure change in mm. after injection	6 to 40	2 to 36	2 to 6	4 to 12	6 to 68	8 to 82	6 to 44	4 to 32
Range of systolic blood pressure change in mm. after E.C.T.	5 to 48	8 to 46	8 to 12	8 to 16	10 to 28	10 to 32	6 to 26	8 to 28
Range of pulse/min. change after injection	20 to 48	24 to 40	4 to 12	4 to 16	0 to 50	2 to 48	6 to 48	6 to 26
Range of pulse/min. change after E.C.T.	24 to 42	24 to 44	4 to 8	6 to 18	8 to 48	8 to 46	8 to 26	8 to 28
% occurrence of pulse irregularities	32	9	0	1	8	4	2	1
histamine-like effects	++	+	0 to +	0	+	+	0	0
headache	++	++	0 to +	0	0 to +	0 to +	+	0
nausea	+	+	0	0	+	+	+	0
subjective ill effects	++	++	0 to +	0	0 to +	0 to +	+	0
secretions	0	0	0 to +	0	++	++	++	++
cyanosis	++	++	++	0	all	all	all	++

"O" is absent "+" is noticeable "++" is excessive.

Each patient was followed up during the day after each treatment and was questioned as to whether she experienced respiratory distress or any other unpleasant side effect of the treatment including memory of it.

The possibility of fracture was kept constantly in mind and each patient was asked whether she experienced any symptoms indicative of this. In doubtful cases radiographic and clinical confirmation was sought.

Results

See Table I for results which are best given in tabulated form. In addition, certain observations regarding each drug are of interest:—

D-tubocurarine chloride

This drug is given intravenously in doses of 15 mg. over a period of 1 minute. It has been found that more rapid injection tended to produce cardiovascular collapse. The drug may precipitate with the ordinary thiopentone preparations and therefore cannot be given in the same syringe.

It was found that relaxation was produced in about 27 seconds and the convulsion could be given immediately thereafter. This contradicts numerous other workers who report that 3 to 6 minutes are required for maximal relaxation.

The time which elapsed before the first respiratory effort was prolonged in spite of the fact that all patients were given assisted respiration. Fortunately neostigmine is a satisfactory antidote if used in emergency only, not routinely, and preferably in combination with atropine. This procedure is not without its own dangers. It is probable that one of the phenylalkylammonium derivatives such as Tensilon may be a safer antidote.

Histamine-like effects, such as laryngeal spasm were found to be very common. Falls in blood pressure immediately following injection were less pronounced than expected, probably because the drug was injected relatively slowly. Bradycardia and pulse irregularities were found in a number of treatments. This effect may be ascribed to the anticholinesterase activity of the drug.

Gallamine-triethiodide

This was given in a dose of 80 mg. It is miscible with pentothal and in this respect differs from d-tubocurarine. Since this drug is a true curarizing agent, it is antagonized by prostigmine, which was required in some instances.

In 3 cases only were histamine-like effects such as bronchospasm noted. Pulse irregularities and tachycardia were frequent, probably as a result of the drug's vagolytic action.

Decamethonium-iodide

The dose of this drug used was 3 mg. This was found to produce an effect equal to 15 mg. of d-tubocurarine and to 80 mg. of gallamine-triethiodide. It may be mixed with pentothal without precipitation. No cases of unduly prolonged apnoea occurred in this series, which was fortunate since there is no satisfactory antidote to the drug which acts by depolarization. Slight laryngeal spasm occurred in only one treatment.

Succinylcholine chloride

This relaxant was given in a dosage of 30 mg. Since the duration of action is brief, it has been argued that precision in dosage is unnecessary, that the duration of response does not increase in proportion to the dose, and that, therefore, all that is needed is to give a fully adequate dose, since this involves merely the expenditure of a negligibly small extra amount of time. A dose of 30 mg. ensures optimal modification of shock therapy, but may be reduced as low as 10 mg. with a corresponding decrease of thiopentone dosage.

Although the drug may be mixed with thiopentone, it loses 20% of its potency within 5 minutes of mixing. It should, therefore, be prepared in a separate syringe. In only one case was apnoea prolonged for a period exceeding 5 minutes. There is no antidote to the drug.

Suxamethonium bromide

This drug was given in a dosage of 30 mg. The active cation of the drug is the same as that of succinylcholine chloride. The effects of the two relaxants were found, as expected, to be exactly similar. For this reason, the results obtained with suxamethonium bromide are not given here.

Suxethonium bromide

This drug differs from suxamethonium and from succinylcholine in its active cation. The number receiving this drug was admittedly small, but results were uniformly good.

2, 5-bis-(3 diethylaminopropylamino)-benzoquinone-bis-(benzylchloride)

Mytolon chloride, a curare like substance, was given intravenously in a dose of 15 mg. which was held to be equivalent to the dosages of the other relaxants tried.

Laudexium methylsulphate

This is a substance closely resembling d-tubocurarine in structure and pharmacologically. It was given in a dosage of 30 mg. It cannot be mixed with thiopentone.

Discussion

Convulsive therapy has been associated since its inception with dangers, prominent among which has been the danger of fracture. Methods of restraint to obviate this possibility are still practised but cannot fail to be repugnant both to the patient and the therapist and do not prevent the occurrence of fracture. Indeed, in many instances, restraint has been a contributory cause. Modification of the current, the glissando technique, and other methods have been tried, but fractures have continued to be reported, some of them having been incurred in the tonic phase rather than in the initial spasm as originally supposed. Modification of the convulsion by chemical means would therefore seem to be the most practical for the purpose; and there can be little doubt that curare and the other relaxing substances which have been described are more reliable and convenient in this respect than the barbiturates and other muscle-softening agents which have been tried elsewhere.

It has been stated that this paper is based on the premise that the use of a relaxant with convulsive therapy is obligatory. This is by no means a uniform opinion. Many ascribe to the belief that the dangers of curare are greater than those of unmodified E.C.T. It is believed that results obtained do not support this view. A further consideration, of no little importance, was the considerable alarm and often terror with which unmodified electro-shock treatment is viewed by many patients, and which cannot contribute to its efficacy. The words "shock" and "electro-shock" have unpleasant connotations for many people and the author prefers "electro-therapy". Many undesirable concomitants of the treatment are greatly eliminated when it is given with anaesthetic and relaxant.

Since the relaxant depresses respiration and may itself be productive of alarm or fear, it is unnecessary to elaborate the contention that its use should always be preceded by the administration of small doses of thiopentone, which also in many cases potentiates the relaxation.

It is realized that fracture may not always be clinically or even radiologically evident, but this possibility was looked for and in all doubtful cases repeated clinical and radiological examinations were carried out and were always negative.

The technique which has been described is held to be the most practicable.

It is desirable that mentally ill patients should receive their shock treatment from the therapist personally responsible for their over-all care. The technique

makes provision for this and also distributes the often wearisome task of giving shock over the whole clinical staff so that each receives his equal share both of training and experience with his own patients, thus improving upon the machine-like and impersonal methods which are all too often encountered. It is assumed, of course, that all participating physicians have training in elementary anaesthetic techniques. The presence of a trained anaesthetist is not held to be necessary.

Shortage of nursing staff is a universal problem, and an obvious one in a private practice setting. The technique described reduces the number of attendants to two or three, and this figure can be reduced still further to one when the number of patients handled is no more than five or six.

As has been suggested, time is held to be an important consideration, although it is the author's belief that its importance has been over emphasized. With all the relaxants described it was found possible to administer an average of 12 treatments per hour without haste or confusion. This may be considered ideal and does not compare unfavourably with the time consumed in unmodified techniques.

The technique is one which excludes the obnoxious and often harmful practice of holding and restraint. The feet are left exposed during treatment since it is there that evidence of a convulsion may often be observed.

The inconvenience of preparing anaesthetic and relaxant in separate syringes is outweighed by the fact that many of the relaxants are not miscible with thiopentone or are destroyed by alkali solutions. When two syringes are utilized, the dose of anaesthetic may be reduced at will. When succinylcholine, suxamethonium or suxethonium are used, the dose of thiopentone may be reduced to 0.10 Gm. because of the short acting nature of these drugs. Similar small doses of thiopentone may be used with decamethomium. There is also the consideration that if thiopentone and relaxant are given together, the effects of the latter frequently become felt before those of the former, and this produces not only immediate distress to the patient, but also distressing after memories associated with sensations of suffocation.

It will be remembered that vagal stimulation may produce hypersecretion with the dangers attendant upon that complication. Reduced ventilation and cardiac arrythmias may also follow. The techniques described therefore included premedication with atropine to counteract parasympathetic stimulation. It is realized that such premedication may not be possible in an out-patient or private practice setting. The most potent argument for the use of atropine is that formulated by Eldridge, (6) who not only mixed thiopentone and relaxant in the same syringe, but also discouraged the administration of atropine in order to spare his patients the effects of a dry mouth. He continued in this method until he himself suffered the distress occasioned by his own techniques and became a convert to the procedure described here.

Although abstinence from food on the morning of treatment may contribute to the nausea which sometimes follows recovery from the convulsion, it is nevertheless believed that this measure should not be waived in any planned procedure involving the use of anaesthetic. The nausea and other after symptoms such as headache may also be due to the anoxia produced by the relaxant drug, and this disadvantage is also partially ameliorated by the insuflation described. It should here be remarked that many of these after symptoms may be the result of emotional states associated with the patient's mental condition and fear of treatment, particularly when this is unmodified.

Inflation with oxygen should be carried out at the end of clonus. It was observed that if oxygenation is carried out before this stage the convulsion tends

to be prolonged. On the other hand, the inflation period was limited to the duration described, since when carried on for longer it had the undesirable effect of prolonging apnoea.

In addition to describing a technique, which has been discussed, eight relaxant drugs were clinically appraised.

No symptoms or evidence of fracture either of long bones or of vertebrae occurred throughout the series of 1863 treatments given to 246 patients, including 7 with recent long bone injury or dislocation sustained prior to the start of treatment, 14 who were aged over 60, and 14 whose physical state rendered the chance of fracture possible. It would seem reasonable to assume that this result may be ascribed to the use of a relaxant, particularly if the result is compared with equal figures from any series of unmodified treatments. Age would not seem to be a contra-indication to the use of modified electro-shock therapy. With regard to the danger of fracture and the factor of age, none of the relaxants tried seemed to have any relative advantage. The possibility of prolonged apnoea is probably the greatest deterrent to the use of relaxants. In the case of d-tubocurarine, gallamine and decamethomium, times to satisfactory ventilation were too long in several instances, while unduly prolonged apnoea occurred occasionally with gallamine, Mytolon and laudexium. Suxethonium bromide was the only drug found to be entirely free from this disadvantage. Succinylcholine chloride, which is considered in this discussion in conjunction with suxamethonium bromide, produced one instance in which the duration of apnoea was considered too long. The production of prolonged apnoea by succinylcholine has been reported by many workers usually in connection with surgical procedures. This danger becomes more alarming when it is recalled that succinylcholine chloride shares with the other choline succinic ester derivatives, suxethonium and suxamethonium bromide, the disadvantage of having no antidote. Succinylcholine acts by inhibiting true cholinesterase and the speed of its action probably depends in main upon the rapidity of removal of pseudo-cholinesterase. In the case of rabbits injection of pseudo-cholinesterase terminates the action of succinylcholine but no satisfactory solution for human application has yet been found. Transfusion with fresh blood would probably act as a satisfactory, if impractical antidote. Grant (10) reported a case to whom 80 mg. of succinylcholine were administered and who developed an apnoea of over 2 days duration. In a case reported by Hodges, (14) apnoea was prolonged 110 minutes. In both these cases the apnoea was surprisingly terminated by neostigmine. The administration of this drug as an antidote to succinylcholine is not to be recommended in spite of these results. Harper (13), Gray (11), McKay (17) and others report that neostigmine prolongs rather than terminates succinylcholine produced apnoea, and in addition increases the possibility of circulatory collapse and of bronchospasm. Thus these workers confirm the theoretical considerations.

If the lack of an antidote be considered an unjustified hazard, and this is not the author's opinion, then use of the other relaxants is not exposed to the same risk. D-tubocurarine is antagonized by prostigmine or by one of the phenylalkylammonium derivatives. Gallamine and laudexium are both antagonized by prostigmine which will also reverse the effect of Mytolon, although its use with this drug is not recommended. The muscarine effects of neostigmine constitutes a further disadvantage of its use. No satisfactory antidote to decamethomium is available, but in emergency pentamethonium or hexamethonium bromide may be tried.

Concomitant physical disease is frequently held to be a contra-indication to the use of relaxants. In this trial all the relaxants were given without ill

effect to a number of patients suffering from a variety of physical diseases.

There are certain conditions, however, whose presence prohibits the use of certain relaxants. Myaesthenia gravis is an absolute contra-indication to the use of gallamine and d-tubocurarine. It is also possible that the latter drug may increase uterine tone and should not be used on pregnant patients approaching term. Any condition likely to produce low cholinesterase levels is theoretically a contra-indication to the use of succinylcholine, suxamethonium and suxethonium bromide. Durrans (5) has pointed out that hyperoxygenation, CO_2 depletion and exhaustion of the Hering-Breuer reflex may prolong apnoea indefinitely, whether that apnoea be initiated by a relaxant or by thiopentone. Cases exposed to the risk of poisoning with organo-phosphorus compounds may have slow cholinesterase regenerative powers. According to Aldridge and Davies (1), persons exposed to such risk include those working with shale oil distillates. It has also been pointed out that low cholinesterase levels may be familial.

The variability of strength of muscle fasciculations appeared most marked in the case of succinylcholine. It was found that if this relaxant is given slowly over a period of about 1 minute, then the strength of these fibrillations was much reduced, but the degree of paralysis was also reduced while its duration lengthened. Strong muscle fasciculations are of course undesirable in cases with skeletal complications.

The presence of cardiac disease all too often serves as a reason for the postponement or cancellation of electro-shock therapy. In this manner, many mentally disturbed cardiac patients are permitted to continue in their distress longer than need be with perhaps further damage to their cardio-vascular systems from emotional causes.

As expected all convulsions were followed by a transient rise in blood pressure and there was an equally transient fall in pressure immediately following the injection of thiopentone. Numerous variables which may affect blood pressure, such as the degree of peripheral resistance and of emotional involvement, invalidate any pronouncement regarding the influence of the relaxants upon this measurement. These transient blood pressure changes were most marked when d-tubocurarine and gallamine were used. The changes in the succinylcholine group were appreciably greater than when the remaining 5 relaxants were used. In these 5 cases changes of blood pressure were not markedly different.

Blood pressure changes also followed the injection of all the relaxants except decamethomium iodide. The changes were most marked following succinylcholine and suxamethonium bromide. They were moderate following d-tubocurarine, gallamine and Mytolon, and minimal after suxethonium and laudexium.

Changes in pulse rate or pulse irregularities followed the administration of all the relaxants except decamethomium iodide, and were minimal in the case of Mytolon, laudexium and suxethonium bromide.

The results showed that patients with concomitant cardiac disease should receive decamethomium iodide or suxethonium bromide as the relaxant of choice in association with electro-shock therapy. It is not suggested that cardiac disease is a contra-indication to this form of treatment.

Suxethonium bromide, Mytolon and laudexium held an advantage over all the other relaxants in regard to the production of histamine-like effects. D-tubocurarine held the least satisfactory position in this regard.

Subjective ill effects such as nausea and headache and including distressful after memories were most frequent following the use of d-tubocurarine and

gallamine. Such effects were entirely absent when suxethonium bromide or Mytolon were used, while the other relaxants occupied an intermediate position.

Suxethonium bromide was the only drug which produced neither excess secretions nor unduly marked cyanosis during treatment.

Succinylcholine, suxamethonium and suxethonium bromide all produced optimal relaxation sooner than any of the other relaxants, but none of the drugs was significantly easier to handle than the others. Consistency of relaxation and optimum modification of the convulsion were found to be greater in the case of succinylcholine, suxamethonium and suxethonium bromide.

An attempt was also made to give a group of patients a trial with each of 6 relaxants. The results obtained in this group differed in no respect from the others and have been included in the results quoted.

There were several instances in which the initial shock failed to produce a convulsion and had to be repeated once or twice. These repetitions were always carried out within 90 seconds of the completion of injection of the relaxant. Such repetitions were required in about 13% of the treatments and the percentage was not influenced by the type of relaxant used.

Since the therapeutic effect of electro-convulsive therapy depends upon the cerebral rather than the muscular component of the artificially produced seizure; since fractures were a commonplace before the introduction of modified electro-shock techniques; since many patients by reason of age or concomitant cardiac disease are denied the acceleration of recovery afforded by electrically induced convulsions—it appears axiomatic that this form of therapy should invariably be given in modified form. The technique described fulfils all criteria for a humane, safe and easy form of treatment, and an attempt has been made to evaluate several of the modifying agents available. Suxethonium bromide rather than succinylcholine chloride is considered to be the most satisfactory. It is realized that this conclusion is based on a relatively small number of treatments with suxethonium. The conclusions have been confirmed, however, by work carried out subsequent to the collection of this material.

Summary

1) An attempt is made to clarify and standardize the technique and modification of electro-convulsive therapy.

2) The literature is briefly reviewed.

3) A technique suitable for outpatient, hospital or private practice use is suggested and discussed. Kindly and proper handling of the patient, the time element, nursing requirements, and the training of medical staff were among the factors considered in the description of this technique.

4) A total of 1863 treatments were given to 246 female patients by the author over an arbitrary period and under exactly similar conditions. The limitation of the trial to females is coincidental.

5) For the first time 8 different muscle relaxants are compared and assessed in the same paper. Six of these relaxants were given to 25 of the patients in a partially unsuccessful attempt to give each of these patients a trial with each relaxant on at least one occasion.

6) It is concluded that physical disease or age do not contra-indicate the use of E.C.T. provided this is modified.

7) It is further concluded that suxethonium bromide is at least as satisfactory, and in most cases more satisfactory, than the other relaxant drugs used for the modification of electro-shock therapy. The drugs were assessed for this purpose in terms of occurrence of fracture, degree of apnoea produced, contra-indications, antidotes, effect upon blood pressure and pulse, production of histamine-like effects, excessive secretions, cyanosis, subjective ill effects, extent of muscle

fasciculations, degree of relaxation, modification of the convulsion, time required, and finally—ease of handling.

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Résumé

Ce travail est une tentative pour dissiper la confusion qui existe sur le choix du curarisant le plus approprié à l'électro-choc thérapie. Huit curarisants sont étudiés:

1. Chlorure de D-tubocurarine
2. Triethiodure de gallamine ("Flaxedil")
3. Iodure de decamethomium (C-10, "Syncurine")
4. Bromure de suxamethonium ("Brevidil M")
5. Bromure de suxethonium ("Brevidil E")
6. Chlorure de succinylcholine ("Scoline", "Anectine")
7. 2,5-bis-(3diethylaminopropylamino)benzoquinone-bis-(benzyl chloride); ("Mytolon")
8. Laudexium methylsulphate ("Laudolissin")

Une technique modifiée d'électro-choc thérapie est décrite.

Les médicaments furent utilisés en dosages de force égale par un seul clinicien travaillant sous des conditions identiques.

La revue de la littérature sur le sujet ne montre pas d'évaluation comparative de ces huit drogues. La plupart des auteurs sont d'accord pour confirmer que le succinylcholine est le médication de choix.

On donne une description d'une technique applicable dans des conditions très diverses, ne demandant que cinq minutes par patient, et favorisant une diminution de l'anxiété qui envahit la plupart des malades avant leur traitement. On administre de l'atropine avant le traitement et on n'utilise aucune contrainte. Le curarisant et le thiopentone sont donnés dans des seringues séparées. On administre de l'oxygène par intervalles durant le traitement. L'utilisation d'un anesthésique, bien qu'utile, n'est pas considérée nécessaire. Une technique qui réduit le temps requis à un temps très court n'est pas désirable, car une telle réduction favorise l'utilisation aveugle des électro-chocs.

L'évaluation des curarisants vise à déterminer lequel de ces curarisants à action courte est le plus fiable pour une modification maxima de l'électro-choc compatible avec la sécurité et le confort du patient, indépendamment de l'âge ou de maladies physiques concomittentes. On insiste sur l'importance de l'absence de souvenir déplaisant après le traitement.

Un total de 1863 traitements fut donné à 246 femmes dont 45 âgées et émaciées ou souffrant de maladie physique associée. La limitation aux femmes de cette étude est purement accidentelle. On inscrit à chaque traitement la pression artérielle et la durée du traitement. On rechercha les réactions histaminoïdes, la cyanose, les sécrétions, céphalées, nausée et le sentiment de détresse. On investigua tous les symptômes faisant craindre des fractures.

On conclut que l'utilisation d'un curarisant dans l'électrothérapie est axiomatique et qu'une maladie physique, l'âge ou une infirmité, ne constituent pas des contre-indications à cette forme de traitement.

Le suxethonium semble au moins aussi satisfaisant et dans la plupart des cas plus satisfaisant que les autres curarisants. Il diffère du succinylcholine par son cation actif. Il est administré à la dose de 75 mg et à cause de sa courte action, la dose de thiopentone peut être réduite de l'habituel 0.25 à 0.10 gm dans la solution aqueuse de 2.5% ou 5%. Il produit un relâchement maximum rapidement sans période d'apnée prolongée. On ne remarqua aucune irrégularité du pouls, de sensations de malaise, de nausée ou de vômissement. Les modifications de la pression furent minimales; les réactions histaminoïdes et les fractures furent absentes. Pas de cyanose marquée, ni d'hypersécrétions.

Il n'y a pas d'antidote au médicament, mais ce n'est pas considéré un risque déraisonnable. Les conditions sujettes à produire une diminution de cholinesterase sont des contre-indications à l'utilisation du médicament. Le nombre de cas nécessitant des répétitions du choc pour produire une convulsion ne fut pas influencé d'une façon significative par le type de curarisant.

CONSIDERATIONS GÉNÉRALES SUR LA PSYCHIATRIE D'HIER ET D'AUJOURD'HUI*

LUCIEN LA RUE, M.D.[1]

Les considérations que je crois devoir faire sur la médecine psychiatrique d'hier et d'aujourd'hui me paraissent un peu hasardeuses et je tiens à déclarer que je n'ai pas la prétention de vous apprendre, aujourd'hui, des choses bien nouvelles. Il y a tellement de gens qui parlent, tellement de gens qui écrivent sur la médecine psychiatrique, et pour nous, les médecins psychiâtres d'il y a 20 ou 30 ans, que le grand public ignorait totalement ou que l'on considérait tout simplement comme "des médecins des fous", je dois avouer que nous sommes devenus un peu perplexes et surpris d'avoir pris la vedette dans la grande presse, dans les grands hebdomadaires, aux réunions des clubs sociaux et même dans les salons des grandes dames distinguées, à l'heure du thé, où celles-ci profitent de l'occasion pour extérioriser la variété de leurs complexes.

Et tous ces gens qui parlent et tous ceux qui écrivent, j'exclus, bien entendu, les revues scientifiques, ignorent, dans la plupart des cas, les lois les plus élémentaires de la biologie. Heureusement que pendant ce temps, pour le bénéfice de l'humanité qui présente des troubles psychiques, il y a eu des gens qui ont continué de penser à la biologie et de raisonner aussi en fonction de leurs connaissances acquises en biologie et en médecine.

Les aliénistes du 19e siècle avaient réalisé un admirable travail de description et de classification des maladies mentales. Celles-ci portaient la marque de l'influence des doctrines constitutionnalistes et, si le mot de guérison était prononcé dans le cas d'une maladie mentale comme j'ai eu l'occasion de le lire dernièrement dans un rapport fait au Ministère de la Santé de Québec en 1900 par le Surintendant de l'Asile de Beauport, il semble qu'à ce moment là, on s'attachait davantage à prévoir le cours d'une maladie qu'à essayer de la modifier, car avec la seule et unique psychothérapie qui, depuis, parait avoir des effets qu'elle n'avait pas, l'on mettait plutôt sa confiance dans le temps, en espérant que les choses s'arrangeraient et quelquefois le miracle se produisait. C'était à peu près les mêmes idées qui avaient cours au moment où j'ai commencé à étudier les maladies mentales en 1924, et j'ai eu l'occasion de voir guérir de ces malades qui, avec le temps et nos pauvres moyens psychothérapiques d'alors, retrouvaient leur équilibre psychique.

C'est vers le même temps que, pour la première fois, j'ai eu l'occasion de voir une grande dame, âgée d'une cinquantaine d'années et atteinte d'hypothyroidie avec les troubles psychiques et physiques inhérents à cette affection, guérir avec des extraits thyroidiens et elle continue de vivre, à l'âge de 82 ans, avec toute sa lucidité d'esprit, en continuant de prendre bien fidèlement sa médication.

Et puis la malariathèrapie de Wagner Von Jauregg est venue modifier le pronostic d'une démence considérée comme incurable; elle marquait une ère nouvelle. Ces constatations ont probablement tellement touché mon subconscient, l'ont tellement imprégné que je suis demeuré peu accessible à la fantaisie. Il s'agit probablement d'un déterminisme dont je n'ai pas été capable de me débarrasser.

C'est dans les mêmes années que la médecine psychiatrique a pris son véritable tournant. Les grands hôpitaux psychiatriques se sont pourvus de labora-

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toires de bactériologie, de sérologie, d'anatomo-pathologie. La radiologie y est entrée elle aussi. Québec a construit son hôpital psychiatrique ouvert, la Clinique Roy-Rousseau en 1926. La ponction lombaire, l'une des premières techniques d'exploration des centres nerveux, est devenue d'application courante; elle permettait de suivre l'évolution biologique des maladies infectieuses de l'encéphale et des méninges. Puis Dandy nous apporta ses techniques d'injection de gaz, de liquide opaque qui permirent de radiographier le cerveau.

A la malariathérapie est venu s'ajouter le choc insulinique de Sakel, puis le choc cardiozelique de Meduna et l'électrochoc de Cerletti. Meniz nous a apporté la lobotomie préfrontale.

Pendant ce temps, la psychologie subissait une évolution considérable et l'on a connu les applications cliniques de la psychométrie; les tests constituent pour nous des auxiliaires précieux de diagnostic et de pronostic et sont utilisées dans tous les grands hôpitaux psychiatriques du monde.

L'on constate de plus en plus, que ceux qui font avancer la médecine psychiatrique sont réellement ceux qui n'est pas oublé leurs connaissances médicales, neurologiques et biologiques. Au milieu de tout ce monde scientifique, les parleurs de phrases ont continué de pérorer et continuent encore. Ils confondent encore la véritable recherche avec les applications d'une découverte qui ne leur appartient pas.

Et permettez-moi de revenir à l'entente fédérale-provinciale dans le domaine de la santé mentale pour vous dire ce qu'elle a permis, à Québec, d'ajouter. Québec avait son hôpital psychiatrique ouvert depuis 1926; on avait organisé en 1938 un hôpital pour épileptiques avec une consultation externe pour permettre aux épileptiques de continuer, autant que possible, à vivre chez eux avec leurs médicaments et à un certain nombre d'entre eux, de gagner leur vie. Cette entente fédérale-provinciale est venu combler les nombreuses lacunes que nous avions, tant du coté de l'équipement que du côté du personnel qui était réellement insuffisant et elle nous a permis de créer des organismes nouveaux, tels les cliniques neuro-psychiatriques et les centres d'examen pour enfants anormaux. Les appareils découlant des travaux de Hans Berger nous permettent, aujourd'hui, d'éclaircir bien des problèmes de comportement et évitent de nombreuses erreurs de diagnostic. La biochimie et ses différentes catégories de spécialistes sont entrées dans l'hôpital psychiatrique. Je pense que, d'eux, principalement, la médecine mentale peut espérer beaucoup et en cela, je le dis sans prétention, je m'accorde avec ce qu'a dit Freud. Je suis en parfait accord avec les opinions émises récemment par Messieurs Bailey et Wiliam Mayer Gross, ce dernier dans son livre intitulé "Clinical Psychiatry"; puis la biologie a continué de faire son chemin. Le Docteur Flemming nous a apporté les antibiotiques qui sont en train de régler définitivement le problème de la syphilis nerveuse.

L'Hôpital Saint-Michel-Archange qui comptait, en 1924 des dizaines de cas de tabès, n'en a plus un seul. C'est une maladie qui appartient pratiquement à l'histoire. Le paralytique général, tel que je l'ai connu avant et après la malariathérapie, n'existe plus.

Cependent toute médaille a deux côtés et nous devons constater que les équilibres naturels sont rompus; que la sélection naturelle n'est plus le même plan qu'elle était et qu'a cause de toutes ces médications biologiques, des quantités d'arriérés mentaux et de séniles continuent de vivre. Ce sont des facteurs qui jouent un rôle important dans le nombre plus élevé des malades mentaux et, à titre d'exemple, l'âge moyen des décès en 1955 à l'Hôpital Saint-Michel-Archange a été de 70 ans alors qu'il était de 52 ans en 1924. La génétique dans certains

milieux est une science qui est complètement ignorée; on ne veut pas en parler, ou nous ne sommes pas capables d'en parler et les cas classiques étudiés comme ceux des familles Kalikak et Jukes par des biologistes, des généticiens, des psychiâtres qui ont amené les Etats-Unis à passer les premières mesures législatives pour empêcher la propagation de certaines tares héréditaires et familiales, ne préoccupent plus nos grands psychotrérapeutes modernes qui voient dans le milieu même, la source de tous les maux. La société n'a plus, pour se protéger, que la défense des mariages consanguins édictés par l'Eglise Catholique.

Et la biologie a continué son chemin. Les neuroplégiques nous sont venus eux aussi de gens qui n'ont pas cessé de penser sans tenir compte des faits biologiques.

Je n'insisterai pas sur les transformations qu'ils ont apportées dans le champ d'action de la médecine psychiatrique, dans la société soit disante normale comme chez les hospitalisés des grands hôpitaux psychiatriques dont ils ont transformé complètement la physionomie. Je crois que, depuis, la lobotomie a vécu, elle a rendu des services, mais l'utilisation des neuroplégiques a posé, surtout pour les maladies de longue durée, des problèmes nouveaux.

Les hôpitaux qui veulent la tranquillité l'ont avec un déséquilibre budgétaire que la société aura à combler. Un certain nombre de nos malades dont en est certain qu'ils continueront, comme les épileptiques, à prendre leur médication, peuvent sortir à condition qu'ils puissent en assumer les frais, ce qui n'est pas le cas pour la majorité et je crois que nous devrons songer à fonder des cliniques externes qui devront assumer les frais de fournir gratuitement les médicaments aux malades incapables d'être suivis adéquatement par leur entourage. La libération de ces malades doit être faite après étude sérieuse et l'appréciation de leur potentiel anti-social devient la responsabilité de tous les médecins d'un hôpital psychiatrique dont les connaissances doivent dépasser la naiveté de ceux qui ont annoncé que les grands hôpitaux psychiatriques deviendraient prochainement inutiles et périmés.

Nous connaissons tous le rôle que joue dans la prévention des dêlits et des crimes, le grand hôpital psychiatrique. Des quantités de sujets que nous gardons et qui dans la vie libre étaient plus ou moins dangereux pour autrui et l'ordre public, et qui, par ailleurs, étaient aussi malmenés, raillés et maltraités, ce qui aggravait fréquemment leur nocivité et leurs inaptitudes.

A l'hôpital, ils vivent heureux et leurs aptitudes sont utilisées. Le grand hôpital psychiatrique reçoit des quantités de malades qui ne sont pas de la formule de l'hôpital ouvert et si celui-ci élargit trop son champ d'action, il s'expose à des accidents de toutes sortes. Je pourrais en citer de nombreux cas. Il en est de même pour les cliniques des hôpitaux généraux qui doivent traiter des malades dans leur formule, avec, comme but primordial, de les traiter de la façon la plus discrète possible sans leur faire courir le risque d'accident et je considère comme une erreur, du moins pour les petites villes, qu'on ait créé dans les hôpitaux généraux, des sections distinctes pour les malades de l'esprit. Il est extrêmement dangereux qu'on voit s'édifier de petits asiles au sein de ces hôpitaux où les malades ne veulent plus aller car ils se disent spontanément qu'on les considère comme des malades mentaux.

Avant de terminer, je voudrais dire un mot de la formation du médecin psychiâtre qui doit, à mon avis, garder d'abord, toutes ses connaissances médicales et dont l'entrainement doit être organisé de telle sorte qu'il doit, pour être complet, faire des stages dans un hôpital psychiatrique où la loi des

hôpitaux psychiatriques de sa province est en fonction. Il connaîtra ainsi, des variétés de malades que l'hôpital psychiatrique ouvert ne peut recevoir et ne peut garder. Il doit aussi connaître les malades de l'hôpital psychiatrique ouvert. Enfin, étudier les malades des cliniques des hôpitaux généraux, les sujets des centres médico-sociaux et les délinquents. Le psychiâtre doit avoir suffisamment de connaissances neurologiques pour débrouiller les maladies psychiques qu'il sera appelé à voir et qui ont une étiologie nerveuse proprement dite. Il doit connâitre la thérapeutique sérieuse scientifique qui met en oeuvre les connaissances biologiques et se méfier de cette thérapeutique littéraire à l'usage des journaux illustrés et des grands quotidiens.

L'exercice de la médecine psychiatrique ne doit pas constituer un commerce et le bien être de ses malades sera fonction de son instruction, de sa conscience, de son humanité, de son intelligence; il devra se rappeler, principalement aujourd'hui, le rôle immense qu'il est appelé à jouer dans la sécurité publique, dans la prophylaxie des délits et même des crimes, en dehors des services thérapeutiques qu'il rendra quotidiennement aux malades qui ont mis leur confiance en lui.

Ses connaissances et son contact avec les médecine de toutes spécialités l'amèneront à jouer un rôle éducationnel auprès de ses confrères. De plus en plus, à cause de lui, s'élimineront certaines interventions chirurgicales inopportunes et à répitition pratiquées chez des personnes dont la cénesthésie est perturbée. Il serait à propos que nous nous préoccupions de nouveau de l'enfant qui vient au monde, pour rappeler à certains obstétriciens que l'accouchement est un acte physiologique qui doit se dérouler de la façon la plus naturelle possible car s'il faut penser à la mère, l'on doit penser que l'enfant a un cerveau et je crois que l'on abuse aujourd'hui des anesthésiques dont les uns ne sont pas sans nocivité. Certains arriérés, certains épileptiques, peut être aussi certains délinquents sont ainsi parce que leur cerveau a été lésé au moment de leur naissance.

L'on parle beaucoup de l'éducation des arriérés mentaux, j'en suis. A ceux qui espèrent trop de leur éducation, je demanderais ce que le monde moderne en fera lorsqu'ils seront parvenus à l'âge de travailler et à moins que l'on prévoit des institutions qui pourront les recueillir et utiliser leur potentiel de travail loin des machines en mouvement, je me demande comment la société pourra régler ce problème depuis qu'existe notre manière syndicale de travailler.

Telles sont les considérations qui me sont venues à l'esprit et que j'ai cru bon de vous transmettre pour vous intéresser et connaître vos opinions.

Summary

The author reviews the major changes and advances which have taken place in psychiatry over the last fifty years, particularly the impact of these on and upon his own professional thinking. He points out the neglect of genetic studies but is encouraged by the greater accent upon biological sciences in psychiatric research.

A note of warning is issued that short term inpatient treatment and outpatient care may permit persons to be in society who would be better protected for their own sake and that of others if they remained in the hospital.

The essential medical nature of psychiatric practice and the need for thorough basic training of the psychiatrist in internal medicine and neurology and a comprehensive experience in a mental hospital is stressed.

Book Review

CRESTWOOD HEIGHTS. A North American Suburb

John R. Seeley; R. Alexander Sim; Elizabeth W. Loosley and collaborators; University of Toronto Press, 1956.

Crestwood Heights is a sensitive sociological case history of a North American suburb written in a journalistic style by trio of Canadian Social Scientists. This volume describes the social life of a Canadian suburban community "with special reference to the child rearing process and its implications for mental health".

The identity of the locality within the periphery of "Big City" is kept anonymous but most Canadian psychiatrists will have very little difficulty to recognize the geographic location of this community. In fact, the National Committee for Mental Hygiene (Canada)—now the Canadian Mental Health Association—which initiated the entire study, described by the writers in an appendix to this book—has made most of us acquainted with this Canadian suburb. Especially the excellent work of the "liaison workers" (teacher—mental hygienists) who now serve as valuable members of psychiatric teams throughout our ten provinces bears witness to the value of the "Crestwood Heights study" which was designated as a research, training and service project.

The social science team which deals in this volume mainly with the research aspect of this study does not contain a psychiatrist. But the absence of the latter—who could have added his psychodynamic, psychopathological and psychiatric epidemiological impressions—is compensated for by the psychiatric sophistication of the authors.

From the beginning of this study, the writers were very well aware of the psychotherapeutic principles in Social Research. They "faced the need of establishing rapport, at a sufficiently deep level to secure the kind of information we needed; of dealing with problems which are essentially the problems of "transference"; and of communicating our insights in non-traumatic ways to the community concerned, or, preferably, allowing members of the community to come to those insights for themselves".

Significantly, the psychotherapeutic principles were not carried into the area of "countertransference". Of this, more later.

Part 2 discusses "Institution and Function". "The Family: Primary Socialization", "The School: Secondary Socialization", "Parent Education: Re-socialization" and "The Club: Sociality" are the individual chapter readings.

Part 3 contains 2 sociological essays on "Laymen and Expert: The Belief Market" and "Beliefs" which could have with very little alteration appeared as separate chapters or as a monograph.

The overestimation of the concept of "mental health" as an important, if not dominant Social value ("Social Values and Mental Health" by one of the co-authors—J. R. Seeley in "The Annals of the American Academy of Political and Social Science"—Vol. 286, p. 15-24) is most probably shared temporarily by a minor segment of the middle classes only!

The community described is somewhat atypical insofar as it consists apparently of a large majority of a middle and upper middle class population and

ethnically the relation between the gentile and Jewish population is more heavily weighted towards the latter in comparison to other similar communities.

The cooperation of the senior and junior citizens of this community with the research team and the readiness to reveal even intimate information bespeak the great skill of the investigators. However, the lengthy descriptions of great details of the material and the behavioral aspect of this Canadian subculture becomes in places almost irritating, most probably because of our own closeness to and our familiarity with such a middle class atmosphere.

The characteristic of the social structure of this community is well defined as "father controlled matriarchy".

Many features of this middle class culture reveal the compulsive, ruminative preoccupation with knowledge especially about human behaviour. However, one receives the impression that new knowledge is not really acquired to serve as a means to the achievement of greater satisfaction in life, but accumulated for narcissistic ends.

In view of this and other internal and external value conflicts the authors significantly state; "If the picture of confusion, internal contradiction, and incompatibility in belief within persons and between them has any veracity, it may well be asked how it is possible in Crestwood Heights for individual human beings to operate as personalities at all, for families to remain visibly intact as families, or, more generally, for action to be concerted in any social act On the basis of the situation described, one might expect very high rates of psychopathology and social disorganization—much higher than any actually found or even suggested".

This seems to corroborate our knowledge about the existence in every culture of more or less effective selfcorrective mechanisms to counteract radical individual and social disorganization. In regards to psychiatric problems in children, the authors give us the following information; "The combined judgement of the clinic and local school personnel was that at any one time perhaps 5 per cent of the child population stood in need of clinical aid. Beyond this, an earlier estimate had it that four times this number could profit by the attention to individual cases of the counselling teams. These figures are rather higher than the estimates for Miami County, Ohio: 5 per cent of the children in need of aid, half of these needing full clinical attention."

From a psychosocial point of view it is significant that a major proportion of the inhabitants of this suburb has reached its present status due to horizontal and/or vertical mobility. On the basis of this information one would assume that neurotic and psychosomatic conditions are quite prevalent in this population (James Holliday, Jurgen Ruesch). An epidemiological study should corroborate the findings of Redlich and Hollingshead according to whom one would expect a predominance of affective, over schizophrenic disorders and that the main forms of psychiatric treatment would be psychotherapy.

These and other hypothesis enter the mind of the psychiatric reader of this book.

Beyond these research speculations this book is also of further interest to psychiatrists.

It serves as an excellent reminder for the psychiatric specialist, especially the psychiatrist in training that the patients, especially those we see in psychotherapy have been exposed to complex environmental influences and still

live outside our offices in a potent social field, that may be pathogenic or supportive. Most Canadian psychiatrists came and still live within the framework of the Social classes described in this volume and the reading of the same may stimulate introspective thoughts on one's own biases and countertransference problems.

The layman's concept of the expert of which we psychiatrists are important exponents may be read also with great benefit. The chapter dealing with this subject should remind us of the danger of accepting and assuming the omnipotence and omniscience ascribed to us by the average citizen. Humility about the transcience of the theoretical basis of our "science" may serve us better than the evangelistic attitude we have assumed during recent years. This humility is especially indicated in view of the authors' following findings:

"The rather unexpected and perhaps extraordinary spectacle presented by a community such as the one studied calls for a radical reconsideration of the whole enterprise of mental health education. As the body of the study will have abundantly made clear, this community is rich in all the means ordinarily thought of as contributory to mental health. Life here is not nasty, short, or brutish. The setting is physically spacious. Time is purchasable in plenty, at least in the sense that reprieve from menial tasks and labor, seemingly pointless in a direct address to instituting the good life, can be bought with relative ease. Institutions, generously endowed, intelligently managed, adequately staffed with men and women of knowledge and goodwill, are not only present or available, but consciously dedicated to those ends and procedures that the mental hygienist recommends. All those means, circumstances, and life-ways in terms of whose absence we habitually account for "pathology", personal or social, are there; and yet, as already indicated, no forcing of the data, no optimism, no sympathy with aims can lead us to suggest that mental health in the community is sensibly better than elsewhere or that after all this effort it is being sensibly improved."

This book is written in a clear, understandable language suited for a large audience, the "mental health experts" as well as the sophisticated laity.

The Canadian edition contains a foreword by Dr. Aldwyn Stokes, Professor of the Department of Psychiatry–University of Toronto, and the American edition carries a lengthier foreword by the American sociologist, David Riesman. ("The Lonely Crowd: A Study of the Changing American Character", Individualism Reconsidered and Other Essays").

Robt. Weil, M.D.,
Halifax.

Annual Meeting — 1957

CANADIAN PSYCHIATRIC ASSOCIATION

The next Annual Meeting of the CPA will be held at the MacDonald Hotel, Edmonton, Alta., June 21st and 22nd, 1957 in conjunction with the annual meeting of the C.M.A.

Members wishing to present papers at the Scientific sessions are requested to communicate with Dr. R. R. MacLean, Chairman of the Programme Committee, Provincial Hospital, Ponoka, Alta. before January 15, 1957.

Correspondence

"Alleged Model Psychoses"

To The Editor, Canadian Psychiat. A.J.

In an article on azocyclonal hydrochloride in your issue of April, 1956, Doctors Sarwer-Foner and Koranyi make some observations on what they oddly call the 'alleged model psychoses'. Fischer's terms seems useful to us. It is euphonious and accurate so that we can only conclude that neither of his critics is acquainted with the use of models in science. No reasonable person expects a model to be identical with the original which is being studied. Indeed, if this were so, one would no longer be using a model, but a copy or facsimile. Models are usually simplifications and sometimes distortions of the original whose function is to broaden and develop and concentrate the artist's or scientist's conception of his subject. Chemists, physicists and astronomers are not so naive as to confuse the numerous models which they use with the 'real thing' for this would vitiate the whole purpose of constructing and observing models whether in clay or thought.

The model psychoses are models of psychotic conditions which can be produced in various ways. Mescaline and LSD 25 are admirable psychotomimetics (mimickers of psychoses) since they reproduce fairly constantly changes in thought, mood and perception with the consequent disturbances in behaviour found in psychotic conditions. Although their article could be interpreted in that way, we can hardly credit that Doctors Sarwer-Foner and Koranyi no longer classify toxic confusional states and deliria as psychoses. Possibly they have some new terminology which has not yet reached us in the West.

They consider that mescaline and LSD 25 model psychoses resemble toxic confusional states (deliria), rather than schizophrenia. They apparently bolster up their viewpoint by saying that the older and European literature put forward this suggestion. We do not see that if an error has been made in the past there is the slightest excuse for perpetuating it. However, had they consulted the most substantial of the older authorities Louis Lewin (whose Phantastica (1) is so hard to get, and which surely would never have been allowed to go out of print), they would have found on page 103 of this classical work that he refers to the peyote phenomena as "a psychosis". He adds "It is significant that in all these abnormal perceptions due to functional modifications in the cerebral life the individual preserves a clear and active consciousness, and the concentration of thoughts takes place without any obstacle. The subject is fully informed as to his state".

Nevertheless, there can be few experienced clinicians who have not been hard put to distinguish very acute schizophrenic illnesses from toxic confusional states.

Some time ago, we came to the conclusion that in some cases any distinction is only possible in retrospect. However, leaving aside these very difficult and rather infrequent cases, the toxic confusional states are, as their name implies, noteworthy for confusion, by which we mean disorientation in time and space combined with a clouding of conciousness. According to Drs. Sarwer-Foner and Koranyi, this then should be a feature of the model psychoses produced

by LSD 25 and mescalin. In fact, however, most of our subjects are very well orientated in time and space and show no clouding of consciousness.

We do not believe that anyone has ever suggested that these model psychoses, which to a greater or lesser degree resemble schizophrenia, *are schizophrenia*. This mistake must surely arise from incapacity to recognize the value and use of models in science. Five years ago, we (2) emphasized that it was very unlikely that we would be able to reproduce clinical schizophrenia experimentally. We have noted this repeatedly. It is disheartening to find this same misunderstanding, which we then encountered, still being echoed with the same sense of righteous conviction. It is a pity to be forced to quote what one might have hoped would by now have become common-place knowledge, but there seems to be no alternative. We then wrote—"It is highly unlikely that the unheralded schizophrenic psychosis of indefinite duration in an unprepared victim and the experiences of a voluntary mescalin taker who knows what to expect and how long his ordeal will last, would be exactly similar. The remarkable thing is that these acute reactions have so much in common. In the accompanying table it will be seen that mescalin reproduces every single major symptom of schizophrenia although not always to the same degree. Subacute and chronic schizophrenia cannot be compared legitimately with acute mescalin poisoning, but should be compared with chronic mescalin intoxication. Very little seems to be known about this condition ..... The objection that all symptoms of schizophrenia are not found in acute mescalin poisoning is not valid. So far as one can judge from little evidence available, the effects of mescalin vary as much, but not more than the symptoms of schizophrenia, which unhappily for psychiatrists, allows a wide variability".

Drs. Sarwer-Foner and Koranyi may have been unable to do experimental work themselves, but a survey of the literature shows very clearly that insight is not always preserved in working with psychotomimetics. This seems to be especially true of the more subtle and unobtrusive ones such as adrenochrome (2) and adrenolutin (3, 4). It is certainly true that some psychotomimetics, such as the poisons present in amanita pantherina and paneolus, the solinaceous poisons derived from datura and henbane and the fierce virola snuff of the Amazon, seem to be more like toxic confusional states; on the other hand, the effects of adrenochrome, adrenolutin and ololiuqui are much more like various aspects of schizophrenia. This, however, simply shows that these model psychoses are likely to help us in studying a wide variety of psychological illnesses.

A critical approach to these important matters is to be commended. But one expects a critic to be aware of the use and value of hypothesis in scientific inquiry. It is often impossible to say whether a hypothesis is "right" or "wrong", many "wrong" hypotheses have been enormously fruitful in encouraging and stimulating research. The hypothesis that model psychoses and the psychotomimetic agents which produce them may increase our understanding of schizophrenia, mental illness generally and the nature of the mind itself, seems from the enormous amount of work which has been recently published, to be one of these fruitful hypotheses (5, 6, 7, 8, 9, 10). Furthermore, we can surely ask a critic to dispose of published evidence by some more sophisticated method than that of asserting that he cannot believe it to be true. Some flaw in the argument, a more illuminating hypothesis or fresh evidence is the usual way of indicating the reasonableness of critical disagreement. A public con-

fession of imaginative limitations though revealing and sometimes even endearing is hardly germane to scientific discussion.

We are, sir,

Yours,
Abram Hoffer, M.D.
Humphry Osmond, M.D.
Saskatchewan Hospital, Weyburn, Saskatchewan.

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Reply to the Foregoing

To: The Editor "Canadian Psychiatric Association Journal".

I have read Doctors Hoffman and Osmond's comments with care. May I be permitted to make the following comments:

That part of our paper concerned with the "alleged model psychoses" referred to Fabing's research on the blocking action of Frenquel on the L.S.D.-25 and mescaline psychoses. We therefore commented on the use of this action (not by Fabing, but in some quarters) in advertisements which implied that the blocking action of Frenquel in these experimental toxic psychoses was evidence in favour of a specific action in schizophrenia (1). Our differentiation is between the "model psychoses" as experimental toxic psychoses, and as "models" of schizophrenia, which we believe are entirely separate clinical entities. Our insistence that the term "model psychoses," taken to mean a model of schizophrenia, is inaccurate and extremely misleading, was in reference to the above context. Nowhere did we say that Doctors Hoffer and Osmond did not differentiate between the two. Doctor Hoffer and Osmond carry the issue much beyond the scope of our original paper. The following comments are therefore in order:

Their apology for using the term "model psychoses" is not one that I can agree with. I prefer to consider the L.S.D.-25 and mescaline psychoses as experimental toxic psychoses, and to use this accurate and unambiguous term which is therefore free from all possible unwarranted inference or implications. It is not

Doctors Hoffer and Osmond's argument that an experimental psychosis is "a psychosis" that I take issue with, but rather the implication that this experimental psychosis is a model of schizophrenia, as compared to a model of a "psychosis". (And the implication is most assuredly there, both in the tendency to equate the two, as cited in our paper (1), and the editorial by Ebaugh cautioning against this use (2). It is present even in the choice of the word "model" by authors who have elaborated a theory of schizophrenia in which some organic, biochemical, abnormal metabolic or metabolical imbalance of the brain and central nervous system, is judged to be the central issue in schizophrenia.)

These latter theories have produced extremely fascinating and illuminating work. Even they should be proved wrong, they have already led to important facets of physiology and biochemical functioning of the central nervous system. As such, I consider them very interesting theoretical constructs, and Doctors Hoffer and Osmond and their colleagues are certainly to be congratulated and respected for being in the *avant gard* of the formulators of these theories.

I nevertheless feel that a scientifically critical and therefore impersonal attitude can be taken by all workers in this field with theoretical visualizations no matter how imaginative, that do not seem to be warranted by the facts. The issue of ultimate right or wrong is less important in scientific controversy than the honest expression of diverging views.

Personally, I feel that the "model psychoses" are no more a model of schizophrenia then, let us say, certain of the psychoses seen in certain brain damaged individuals. Examples of this are seen in certain paranoid reactions in G.P.I. or, for that matter, in certain toxic psychoses seen in pernicious anaemia or lobar pneumonia. This is especially true if we select those cases in which delirium, i.e., a clouding of consciousness, is absent. What we then see in such cases is the distortion of pre-existing personality by disease which has produced diffuse metabolic changes, and varying degrees of cerebral impairment. In our paper referred to, we suggested that the L.S.D.-25 and mescaline psychoses produced constant distortion in . . . "apperception, i.e., are distortions to both internal and external sensation. Changes in mood and anxiety are less constant. It can be speculated that these are secondary to the effects produced on the pre-existing personality by the disorder in apperception." (Page 96, 3)

I work with a somewhat different theoretical orientation to schizophrenia then Doctors Hoffer and Osmond (a paper on this is forthcoming). I do not know whether I am right, but I feel that schizophrenia is such a vast area of research that there is ample room for multiple diverging opinions and approaches, since at present no one has all the answers. Much good work should come from these divergent approaches, and it is in this that the fundamental hopes for solving many of the mysteries in this condition lie. Personally, I follow the work of the Saskatchewan group with great interest, and, may I assure them, with a critical but not unfriendly attitude.

I am, Sir,

Yours,

G. J. Sarwer-Foner, M.D.,
Queen Mary Veterans Hospital,
Montreal, Quebec.

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Re-habilitation of Alcoholics

The Editor, Canadian Psychiatric Assoc. Journal:

The State of Florida has organized a programme for the rehabilitation of the alcoholic on a large scale. The financing of the whole programme by the State of Florida is covered by the government taking one per cent of the taxes that they collect from the sale of all alcoholic beverages in the State.

So far they have a clinic in Pensacola, Tampa, Miami and Avon Park. Of these clinics Miami and Avon Park have also the facilities to take in patients. They have erected a completely new building at Avon Park exclusively dedicated to the rehabilitation of acute cases, with facilities for 50 patients of both sexes plus large out-door services.

It was on the occasion of the inauguration of the hospital at Avon Park that the Clinical Director of the Rehabilitation Programme decided to organize a long week-end work shop for the staff of all the clinics and hospitals working in the programme.

I arrived at Tampa on the afternoon of Thursday, June 21st. Immediately after supper I visited the clinic, which begins to function at 7.00 p.m. daily. At the clinic there is a psychiatrist, a psychologist and a very well trained social worker. The psychiatrist does the intake of the patient, and decides about the further treatment. The fact that this clinic has no facility for in-patients means that no acute cases can be admitted for treatment, and when such patients arrive, the psychiatrist and the social worker see to it that they are accepted in the general hospital. They follow the course of the dis-intoxication, and once the patient is discharged it is arranged that he will attend the clinic for therapy.

The interesting thing to notice is that there is practically no individual psychotherapy carried on, all the treatments are carried in groups. The whole staff, including psychologists and social workers conducted group therapy meetings.

The work of the clinic has been so successful, so far, in spite of the fact that they have been working for only a few months, that they are now considering increasing the professional staff to meet with all the needs of the community.

I found very stimulating certain experiments that they are doing in group therapy, mainly conducted by the social workers, namely:

(a) group discussion with the spouses of the alcoholic patient

and

(b) with their children.

The results, so far, of the discussions with the spouses of the alcoholic, have been tremendously encouraging. The non-alcoholic spouse quickly gains insight into the main motivations for drinking, with the result that they have been extremely helpful, and in many cases marriages which were on the edge of breaking down have been successfullly maintained. As far as the results with the children are concerned, the experiments are still too recent to draw any conclusions, but it was obvious from the conversation that the therapists are very hopeful.

It was particularly gratifying to see that all the therapists working in the clinic made constant use of "film therapy" following the principles outlined by myself in some articles published some time ago.

On Thursday evening, June 21st, there were three groups going on, of which I attended only one. At the end however, the patients of all the three groups, around 30 in number, including patients, spouses and children met together to see the film "Feelings of Hostility". The showing of the film was followed by a long period of questions, in which I was amazed by the participation of so many

members, which lasted until 11.30 p.m. At the end of this group discussion, I met the staff of the clinic, also some members of the Pensacola clinic who had just arrived for the Avon Park meeting, and a long, informal, very alive discussion about the psychotherapy of alcoholics was carried on until 1.30 a.m.

On the morning of Friday, June 22nd, we drove to Avon Park, and the workshop, consisting of about 30 people, including physicians, psychiatrists, psychologists and social workers, started immediately after lunch and continued until 7.00 p.m. The general psychotherapeutic approach to alcoholism and the physical treatment of the acute cases were the two main topics for discussion. The Administrators of the programme and some of the leading members of the "A.A." in Florida were present.

The next morning, Saturday, June 23rd, the role of the social worker in the rehabilitation of alcoholics, both in hospital and the out-door clinic was fully discussed. After a lunch a long discussion, of nearly two hours, followed the presentation of my paper on "Psychotherapy of Alcoholics", both from an individual group psychotherapy point of view.

M. Prados, M.D., Montreal

THE AMERICAN PSYCHIATRIC ASSOCIATION

DIVISIONAL MEETING

November 8, 9, 10, 11, 1956

Sheraton-Mount Royal Hotel, Montreal, Quebec

PROGRAMME

Thursday Morning — November 8

9.00 REGISTRATION ($5.00)

9.30 Dr. Francis Braceland – "Kraepelin, His System and His Influence"
Dr. C. B. Farrar – "Kraepelin and His Heidelberg Clinic"
Dr. Frank Beach – (Academic Lecture) "Comparative Studies on Sex Drive"

Thursday Afternoon

2.00-3.00 Dr. Hadley Cantril – "Perception and Interpersonal Relations"

3.00 Dr. N. B. Epstein – "Experiences in Family Research Study"
Dr. M. A. Tarumianz – "Social Adjustment Follow-up of Emotionally Disturbed Children"
Dr. J. S. Tyhurst – "Morbidity, Mortality and Industrial Retirement"

3.00 Dr. Max Fink – "Relation of Tests of Altered Brain Function to Behavioural Changes with E.C.T."
Dr. A. Morello – "Physiological Changes Occurring with Electroshock"
Dr. D. J. Lewis – "The Therapeutic Use of Lysergic Acid Diethylamide"
Dr. Edwin Dunlop – "Observations on the Funkenstein Test"
Dr. D. J. Impastato – "The 'Molac II' – An Alternating Current Electroshock Machine Incorporating a New Principle"

Thursday Evening

6.00 Cocktail Party

8.30 PUBLIC LECTURE – Dr. Arnold Gesell – "Psychology of Growth"

Friday Morning — November 9

9.00 Dr. Nathan Kline – "The Nature of Schizophrenia"
Dr. Robert Heath – "Recent Studies in Schizophrenia"
Dr. P. L. McGeer – "Aromatic Excretion Pattern of Schizophrenics"

Friday Afternoon

2.00 Dr. W. Mayer – "The Kraepelinian Era and the Present Pharmacotherapeutic Trend"
Dr. M. Straker – "The Contemporary Psychiatric Scene"
Dr. E. T. Carlson – "ARMARIAH BRIGHAM – His Psychiatric Thought and Practice"
Dr. W. A. Triebel – "Post-Partum Mental Illness"
Dr. J. D. Armstrong – "Follow-up of Alcoholic Patients"

2.00 Dr. J. N. Fortin – "Group Psychotherapy with Peptic Ulcer"
Dr. Ian Alger – "The Development of Tyrannical Behaviour in Severely Disabled People"
Dr. J. L. Langlois – "Diagnostic and Therapeutic Aspects of Passive-Dependent Behaviour"
Dr. Karl Stern – "Observations on a Ceramics Workshop"
Dr. Hyman Spotnitz – "A Pre-Analytic Technique for Resolving the Narcissistic Defence"
Dr. Abram Blau – "A Brief Analysis of the Nature of Psychotherapy"

Friday Evening — Banquet and Dinner Dance

Saturday Morning — November 10

9.00 Dr. W. C. M. Scott – "Noise, Speech and Psychotherapy"
Dr. Philip Weissman – "Some Aspects of Sexual Activity in Fetishism"
Dr. E. Wittkower – "Psychoanalysis as Science – A Psycho-Physiological Approach"
Dr. Andre Lussier – "Castration Anxiety in Analysis of Patient with Congenital Shortening of the Arms"

9.00 Dr. A. Sainz – "Screen Study of the Concept of Sedation"
Dr. V. Kinross-Wright – "A Critical Study of Promazine Therapy"
Dr. H. Lehmann – "Differential Screening of Phrenotropic Agents in Man"
Dr. S. Wilner – "The Use of Gravol as an Adjunct to Supportive Psychotherapy"
Dr. L. H. Rudy – "The Effect of MER-22, a new CNS Stimulant"
Dr. H. C. B. Denber – "Chlorpromazine in the Treatment of Mental Illness"
Dr. H. Azima – "The Use of Dream Inducing Capacity of Rauwolfia Serpentina"
Dr. E. B. Kris – "Follow-up Study on Thorazine-Treated Patients"

Saturday Afternoon

2.00 Dr. C. J. Sager – "The Impact of Divergent Theoretical Viewpoints in Training for Analytic Psychotherapy"
Dr. W. L. Sands – "Role of Psychoanalyst in Psychiatric Residency Training Program"
Dr. G. M. Lott – "Psychiatric and Mental Hygiene Services for Colleges and Universities"
Dr. F. D. McCandless – "Relation of Student Anxiety to Concepts of Role and Medical Care"

2.00 Dr. R. S. Mumford – "Collaboration Between Psychiatry and Other Specialties in a General Hospital Clinic"
Dr. Ian Kent – "Iris Pigment Scale Studies in Schizophrenia"
Dr. U. Sternberg – "Evaluation of Chlorpromazine-Reserpine Patients"
Dr. A. C. Sherwin – "Studies of the Vascular Bed of the Bulbar Conjunctiva in Psychiatric Patients"
Dr. E. O. Niver – "The Personality Reaction to Adrenalin and Histamine"

5.00 Civic Reception

Sunday Morning — November 11

10.00 Dr. R. K. Greenbank – "Unexplained Mental Phenomena Regarding Suicides"
Dr. W. G. Eliasberg – "Art – Immoral or Immortal?"
Dr. M. Ullman – "The Biological and Social Roots of the Dream"
Dr. H. A. Bowes – "The Psychopathology of the Hi-Fi Addict"

Noon Luncheon at Prevost Sanatorium

***REGISTER NOW*—WRITE DR. ALAN MANN, THE MONTREAL GENERAL HOSPITAL, MONTREAL, QUE.**

Proceedings of The Sixth Annual Meeting of the Canadian Psychiatric Association*

The President called the meeting to order at 3.15 p.m., June 15, 1956 in Quebec City. Approximately fifty members were present.

President's Report

In presenting his report as President, Dr. McKerracher expressed gratification that at the meeting of the Board of Directors the evening before, every province but one had been represented. He stressed the need for continuous action in the operation of C.P.A. affairs during the year and felt this might be achieved by more effective Provincial activities. While he had no specific suggestions to make, Dr. McKerracher said he hoped that the matter would be discussed by every provincial group during the coming year.

Reporting on one of the important functions of the President, Dr. McKerracher said he had exchanged many letters with various professional organizations on matters of mutual concern—the Canadian Medical Association, Royal College of Physicians and Surgeons, etc. In regard to the C.M.A., he said, his only suggestion as President was to take advantage of the good spirit which had been exhibited by the C.M.A. toward C.P.A.

Discussing the relationship between C.P.A. and the Royal College, the President said that C.P.A. was currently fretting about the policy of the College regarding the relationship of certification to Fellowship training. During the year the Committee on Professional Standards had discussed this matter most thoroughly. The C.P.A. proposals to the College had not been accepted in their entirety. However, the alternatives of again presenting the C.P.A. case or of withdrawing from the Royal College made an easy choice, Dr. McKerracher said. He felt that in time the College would see our problems and that the C.P.A. could benefit ultimately from the good offices of the College which was made up of men of good will who lacked only a little understanding of the problem of training psychiatrists.

Dr. McKerracher stated that one of the reasons for the birth of the C.P.A. was the desire for an organization that was essentially Canadian. This, he said, was a splendid motive and the C.P.A. today was proof of its wisdom. He said he wished however to present a note of caution. He was aware of a spirit of nationalism that had risen within the C.P.A.—a rising tide of antagonism towards the American Psychiatric Association. While it was a good thing, he felt, to be proud of C.P.A. and it was understandable that we should be a little jealous of competition, he reminded the members that psychiatric patients and psychiatry as a whole had benefited greatly from the efforts of the A.P.A. and from its generous sharing not only of its knowledge but also of its accomplishments. He felt strongly that the nationalistic ideas which seemed to be apparent in various

*Editorial Note — Since it is usual for less than a fifth of the members of the CPA to have an opportunity to attend the Annual Meeting, the Journal is undertaking on a trial basis the publication in edited form the proceedings of the general business meeting. As the past president pointed out in his address, it is important that matters of policy and opinions emanating from this association should be subject of discussion at provincial branches and affiliate societies' meetings. It is in this way that the provincial directors can present a representative view at meetings of the board. For this reason the reports of committees of our colleagues, who devote much time and interest to the work of the association will be set forth *in extenso*.

parts of Canada should be kept under control and that the C.P.A. should endeavour to work in harmony with the American Psychiatric Association.

Dr. McKerracher spoke of the commendable work of the Committee on Psychiatric Services of the Canadian Mental Health Association under the Chairmanship of Dr. Tyhurst who had presented a report of the committee's work at the scientific meetings early in the day. This committee, the President said, was composed mainly of C.P.A. members but the C.P.A. would not have been able to carry out such a project on its own and therefore owed a debt of gratitude to the C.M.H.A. and to Dr. Griffin under whose aegis this important committee had carried out its work. The result of this work was a report containing proposals and recommendations which Dr. McKerracher urged psychiatrists across the country to examine and consider seriously.

In closing, Dr. McKerracher referred again to the evidence of growth and vigor in the C.P.A.–like the President of the United States, he said, it had never looked healthier. However, he had a word of warning–the responsibility for the health had been left too much to one person–Dr. Roberts. Dr. Stogdill had assisted ably at the birth and Dr. Roberts had carefully nurtured the growing organism. In the beginning, he said, it was inevitable that one man or group of men must take most of the responsibility but the time had come when, if C.P.A. was to look after the professional and economic interests of its members, every members must share the responsibility for Association affairs. Dr. McKerracher expressed thanks to Dr. Roberts; Dr. Hamilton the Treasurer; and to Dr. S. R. Montgomery chairman of the Membership committee, who during the past year had done an outstanding job in recruiting new members. He also thanked the Program Committee who had achieved such a successful meeting in the historically beautiful capital of French Canada. Finally, Dr. McKerracher said, he would be glad to hand over the honour and the headaches of the Presidency to his successor.

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Secretary's Report

Dr. Roberts reported that until the previous evening there had not been a meeting the Board of Directors since the last Annual Meeting in June 1955. Despite concerted efforts to hold a meeting in Toronto in February, a quorum had not been achieved. Geographic hazards and the lack of funds to defray travel expenses for Directors were very real problems in conducting Association affairs during the year. He felt that ways and means must eventually be devised to ensure the proper conduct of business meetings during the year, either by the establishment of a small executive committee or by provision of funds for holding regular meetings of the Board.

The present situation regarding affiliated societies is as follows: To date C.P.A. has six affiliates–the Newfoundland Psychiatric Association; the Maritime Division of C.P.A. comprising the provinces of P.E.I., Nova Scotia and New Brunswick; the Ontario Neuropschiatric Association; the Neuropsychiatric Section of the Manitoba Medical Association; the Saskatchewan Psychiatric Association and the Alberta Psychiatric Association. Two of these groups, the Ontario NP Association and the NP Section of the Manitoba Medical Association, have a very loose type of affiliation with C.P.A. whereby they maintain complete independence as to membership, by-laws, finances, etc., but extend mutual assistance and support of common objectives.

The Newfoundland Psychiatric Association, the Maritime Division of C.P.A., the Saskatchewan and Alberta Psychiatric Associations have close affiliations with C.P.A. Their constitutions were drawn up in line with that of C.P.A.,

members of these groups were expected to be members of C.P.A., and it was hoped that the parent body could pass back to these local groups as much responsibility for C.P.A. activities as possible. It is inevitable that in the early years of organization and growth there would be some pitfalls, Dr. Roberts said. Lines of communication sometimes become tangled, but, with mutual understanding of policies and responsiblities and concerted efforts in the part of each and every member, he said he was confident that C.P.A. could go forward to take its place in the front line of specialist medical organizations in Canada.

At the request of the Royal College of Physicians and Surgeons of Canada, C.P.A. had again submitted nominations for the Specialist Committee on Psychiatry. The committee as nominated was subsequently appointed by the Council of Royal College and would hold office until December 1957.

During the year, the Board of Directors was asked to consider and discuss with their colleagues the proposal of the American Psychiatric Association to seek incorporation in Canada. As a result of the expressed opinions of the Directors, the A.P.A. was informed that C.P.A. would be prepared to give support to the incorporation of A.P.A. in Canada and that at some future date C.P.A. would like to consider the possibility of cooperation with A.P.A. in the operation of the latter's Canadian activities. Dr. Roberts said that subsequently, at a meeting of A.P.A. Council in 1956 the Association's legal counsel indicated that it was unlikely that APA could be incorporated in Canada because the original incorporation seemed to preclude any subsequent incorporation in another area. The matter was being pursued further with the Attorney General of Canada to see whether registration or other legal recognition would be possible.

As a member of the International Congress of Psychiatry, Dr. Roberts told the meeting that the association continued to cooperate with the Congress Organizing Committee for the meeting to be held in Zurich, Switzerland in 1957. The Cunard Steamship Co. had informed C.P.A. that attractive fares would be available for Canadian psychiatrists planning to attend the Congress.

Dr. Roberts continued with discussion of a matter which he said he felt warranted serious consideration by the CPA membership at large—that of members in good standing who reach the age of retirement from salaried positions or from private practice. According to the Constitution three courses are open to them—first, they may continue to pay their fees as active members; second, they may apply for *inactive* membership if they have been active members in good standing for 10 years or more; and third, they may be elected to honorary membership. The Constitution limits the number of honorary members to 10 and already five have been elected so this leaves little provision for these members who will reach the age of retirement as CPA continues to progress.

During the year the Association learned with regret of the death of one of its older members—Dr. W. A. Dobson of Vancouver. Dr. Dobson who was a native of Nova Scotia had been active in the psychiatric field in B.C. since 1920 and had been the director of B.C.'s first child guidance clinic.

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Treasurer's Report

June 1, 1955 to December 31, 1955

Statement of Receipts and Disbursements

Bank Balance at May 31, 1955	$ 2,636.58	
Receipts June 1, 1955 to Dec 31, 1955	857.40	$ 2,759.56
Disbursements June 1, 1955 to Dec. 31, 1955	734.42	734.42
Balance at December 31, 1955		$ 2,759.56

Breakdown of Receipts and Disbursements

Receipts		
Membership Dues	$ 802.30	
Annual Meeting	55.10	857.40
Disbursements		
Annual Meeting	174.95	
Bulletin	337.95	
Printing and Stationery	32.00	
Stenographic and Clerical Assistance	125.00	
Bank Charges	14.52	
Auditor's Fee	10.00	
Postage	40.00	734.42
Surplus of Revenue over Expenditures		$ 122.98

R. C. Hamilton, M.D., Treasurer, moved adoption of this report.
CARRIED.

* * * * *

Committee on Professional Standards

"I hereby submit the following report of the activities of the Committee on Professional Standards of the Canadian Psychiatric Association for the year 1955-1956.

As usual, most of the activities of the Committee have consisted of long and cumbersome negotiations with the Royal College of Physicians and Surgeons of Canada, most of which have come to naught. Certainly, there is no doubt that at our present speed of reaching agreement with the Royal College, there will be a job for this Committee or a similar one to do throughout the lifetime of all of use. However, some minor accomplishments have been gained during the year and I will first outline these.

A Committee of the Royal College of Physicians and Surgeons on the revision of regulations and requirements, reported to the Council in early October, 1955, and as a result there were several changes in the regulations and requirements for psychiatric certification and fellowship. This Committee had before it, a brief submitted by the Committee on Psychiatry by the Royal College of Physicians and Surgeons under the Chairmanship of Dr. Aldwyn Stokes and since there was a rather interlocking membership of that Committee and the Committee for which I am reporting, the Canadian Psychiatric Association Committee was able to express its views as well. A good many of the recommendations of this Committee were ignored by the Royal College Committee but as I mentioned, several changes were made which are of some importance. To outline the submissions and decisions concerning them briefly:

1. In the requirements for both the Fellowship and the Certification Examination in Psychiatry, the previous statement had been as follows:

   "Two years of approved resident training in psychiatry—one of these years must be spent in a general hospital approved for resident training in psychiatry."

   The wording of this was changed to read;

   "Two years of approved resident training in psychiatry, not more than one of these two years may be spent in a mental hospital".

2. In the requirements for certification examination in psychiatry, the Committee recommended that alternative (3) in the section having to do with the two further years of training, be deleted. This section read;

"Six months of approved full-time study of the basic sciences and six months of approved residency in internal medicine or general surgery."

The Committee felt that the basic science part of this was covered by a previous section and that the second six months perhaps could be spent in a more useful sort of way than as a resident in general surgery. However, the Royal College Committee decided that this regulation should be retained.

3. A change was made in the statement regarding the oral and clinical examination for the Fellowship in Medicine as modified for psychiatry as follows:

"An oral examination in applied bacteriology and pathology. The examination shall be conducted by a Board of Examiners representing Medicine, Pathology and Psychiatry. Emphasis will be placed on the development of morbid processes in the physical, psychological and social fields that result in psychiatric disability. The candidate will be expected to demonstrate a broad knowledge of gross pathology; relatively less stress will be placed on the recognition of histological sections and technical bacteriology but a knowledge of cellular, and immunological reactions as part of general pathological principles will be required."

The change here is in the sentence dealing with the,

"development of morbid processes in the physical, psychological and social fields that result in psychiatric disability"

which we felt is a statement which is more acceptable than that which is held heretofore, i.e., "Emphasis will be placed on the general principles of pathology and bacteriology, pathogenesis, pathological physiological changes and their clinical applications to psychiatry and to psychopathology.

4. Finally a change was made in the statement regarding the oral and clinical examination for certification in psychiatry. The previous reading of this section was as follows:

"The candidate will be asked questions dealing with the general principles of medicine, pathology and the related basic sciences necessary to the proper understanding of psychiatry as well as with the principles and practices of psychiatry and in addition, will be examined on assigned patients."

The new reading is as follows:

"The candidate will be asked questions on the physical, psychological and social aspects of psychiatry as well as on the principles and details of psychiatric practice. A clinical examination on assigned patients will be conducted."

While we did not gain all that we wished out of this, it does seem to the members of your Committee that these statements do represent some advance in our trying to straighten out the muddle of psychiatric education and qualification in Canada.

When we come to other matters, the success of our negotiations has not been as great. One of the things which was strongly urged by this Committee directly and through the President of the Association was the provision of adequate representation on the Council of the Royal College of Physicians and Surgeons of the various specialist groups across Canada. Since there are twenty-four members on the Council, it was suggested that a fair representation would be eight physicians, eight surgeons and eight members from the specialist groups who would rotate from time to time. In this way, it was felt that proper specialist representation could be gained and it would be understood that such representatives would be there to

present the viewpoints of their specialists organizations regarding training, etc. However, the College were not able to accept this recommendation but they did modify their statement regarding the Council as follows:

> "The Council shall consist of the immediate Past President Ex Officio and twenty-four members, (twelve physicians and twelve surgeons) elected among the Fellows as follows: a) at least one member of Council shall be from the teaching staff of each of the twelve medical schools. They could be representatives either in the medical or surgical divisions, b) the remaining twelve members should not necessarily be chosen from university teaching staff but should be selected after taking consideration of geographic representation, c) a certain number of specialists should be elected to Council, not particularly to represent one specialty but to represent the specialty group as a whole".

This new arrangement was put into effect this Fall and a member of our Committee, Dr. John Dewan was elected to the Council of the Royal College.

To some extent then, we have achieved the purpose that we wished, namely a direct mode of communication to the Council of the Royal College but Dr. Dewan is in a rather difficult position since he is there not as representing psychiatry really, but merely as one particular specialist who was chosen by the College without particular regard to any representation. While we therefore have achieved our goal in actual practice, we have certainly not had any recognition of the philosophy behind this goal and the Committee did not feel that this was a satisfactory response to our request.

Following consultation with the members of the Executive Board it was decided to ask the President to express further dissatisfaction to the College and to sound out the other specialties of Canada regarding their feeling about establishing an organization of the specialties of Canada who would speak for the whole specialty group to the Royal College. He has done this in an unofficial way and I believe that in general, the response from the other specialist groups are satisfactory. It would be the recommendation of this Committee that these efforts be pursed in the coming year.

The third issue which was discussed with the Royal College was the question of the relative standing of the Certification and Fellowship Examination. There is no doubt that in the minds of hospital administrators, other physicians and the general public at large, the Fellowship qualification implies a higher standard in training and experience than does the Certification. However, as far as psychiatry and the other specialties are concerned this implication is not borne out by the facts because it may well be possible for a man to get his Fellowship in Psychiatry with less actual pyschiatric training than the candidate for the Certification is required to have. Since the bodies concerned are quite likely to make practical application of their beliefs regarding the Fellowship and Certification in drawing up rules for their various institutions, one felt that the Royal College statement should point out that while the Fellowship Examination required more training and proficiency in general medicine and general surgery and the basic sciences, it did not require or testify to more training or knowledge in the specialty itself. This recommendation was made to the College but was turned down by their Committee as not in accord with the general principles of the College. I feel that this issue is an important one in the development of psychiatry in Canada and while I am not sure that the method which we suggested to deal with it during this past year is the proper method to follow, I am sure that something should be done about this. The Committee would recommend then that the new Committee give further study to this problem and attempt

to work out some formula which would allow for these qualifications to be translated into a more accurate estimate of an individual's experience and ability.

Turning to other matters which have been on the fringe of your Committee's activities during the year, a question is still left unanswered that I asked at this meeting last year, namely once we have established a satisfactory communication with the Royal College and other bodies, what do we wish to communicate to them? During this past year, there has been a good deal of discussion about the standards that should be set up for psychiatric training both at the undergraduate and graduate level but there is little agreement and as yet, your Committee has nothing to recommend in these areas. Again however, such standards with the preparation of a definite syllabus for examination particularly at the Certification level would certainly be a very useful step at the present stage of Canadian psychiatry and should also be recommended to the incoming Committee.

Finally, complaints have been received from several quarters regarding the inadequacies of present descriptions of training facilities for psychiatrists in Canada. The most pressing need for such information is from the American Psychiatric Association and your Committee has offered to prepare a statement regarding training facilities in Canada which can be incorporated in the American Psychiatric Association listings and can be used for individuals who need accurate information regarding such possibilities. Unfortunately, your Committee's activities have not gone beyond the offering stage so that they are now committed to this project and hence would also recommended this to the new Committee.

All of which is respectfully submitted."

R. O. Jones, M.D., Chairman
D. E. Cameron, M.D.
F. Cote, M.D.

In discussion of this report, Dr. D. E. Cameron pointed out that the membership should realize that the action of the Royal College in appointing specialists to the Council was occasioned only by a most massive response across the country to the revision of the Regulations and Requirements of Graduate Training related to the specialty examination in 1954. The specialist groups raised such a protest that a special session was arranged by the Royal College at which he (Dr. Cameron) spoke on behalf of CPA. Only because of this CPA got itself heard. Continuing, Dr. Cameron pointed out that in Canada the specialty groups were as numerous in respect to numbers as were internists and surgeons. If the Royal College was to be really representative of medicine in Canada, he said, it must have representation from specialty groups on its Council. Dr. Cameron said another important aspect of the report of this committee was that of Fellowship examination. He and Dr. Stokes were more involved than anyone with the examination system of the College. He was reasonably satisfied, he said, they were able to negotiate with the College for satisfactory arrangements for certification examinations. But, he informed the meeting that CPA members should understand that the Fellowship examination was not in the hands of psychiatrists. No group of psychiatrists can pass a man for Fellowship nor can he even recommend himself to the College. This was a most unfortunate state of affairs for many reasons, Dr. Cameron said—one very practical reason being the growing feeling across the country in general hospitals and universities that men should not be promoted to higher rank or admitted to faculties or staffs of hospitals unless he had his Fellowship. Dr. Cameron said he could foresee the time when we may be forced to revise training programs.

Dr. Cameron moved an amendment to the report:

> THAT the Fellowship examination of the Royal College of Physicians and Surgeons in medicine as modified for psychiatry should be regarded as unsatisfactory in its present form and is therefore detrimental to the proper training of psychiatrists.

In seconding the amendment, Dr. Stokes said that there must be some unanimity as to whether psychiatrists in four years of training should have one year in general medicine—most people will say this is not so while others will say it is so. Dr. Stokes said it must be remembered that the College has a core of charter members who look on it as a College of Physicians and Surgeons and who look on certification by the College as equivalent to the American Board of Psychiatry. The specialties had obtained entry into the Royal College and were becoming very powerful. Some specialties, he said, do agree that one year of medical training is necessary. He felt that the CPA committee on professional standards should seek quite specifically a declaration from the College as to policy.

Dr. Jones said there was a very definite attitude of the College regarding definition. The name of the examination is "Fellowship in Medicine as Modified for Psychiatry". As long as it is a Fellowship in Medicine the pathologist and internist will insist that a certain standard of pathology, etc. be reached. Dr. Jones felt that a very basic change was needed in the philosophy of the College regarding the Fellowship in psychiatry.

The amendment was put to a vote and CARRIED.

Discussing the function of his committee, Dr. Jones felt that it should draw up certain standards for training—both for certification and Fellowship in Psychiatry so that examiners would have information regarding the same type of training across Canada and thus be able to set examinations. Dr. Jones moved—

> THAT the Committee Professional Standards proceed with a definite syllabus for examination at the certification level and later at the Fellowship level in order that the Canadian Psychiatric Association might understand the training of psychiatrists.

Seconded by Dr. Silverman, CARRIED.

Dr. Jones moved adoption of the report as amended. Seconded by Dr. Cameron. CARRIED.

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Report of Committee on Training and Standards for Electroencephalographers

A meeting was arranged at Kingston General Hospital by Dr. Dennis White Jan. 56 at which representatives of the Canadian Psychiatric Association were invited to meet with representatives of the Canadian Neurological Association for purposes of trying to establish standards for accredited electroencephalographers. Those in attendance were: Dr. Malcolm Brown and Dr. John Dewan representing the Royal College, Dr. Dennis White of Kingston, Dr. Jasper of Montreal and Dr. Jack Scott of Toronto representing Neurology, Dr. Shagass of Montreal, Dr. J. M. Rae of Toronto and Dr. A. Bonkalo of Toronto representing Psychiatry. I was previously asked at the last Annual Meeting of the Canadian Psychiatric Association to serve as Chairman of a Committee on EEG Standards of the C.P.A. by Dr. McKerracher, President of that organization.

Following a fairly lengthy discussion on what was happening in Canada and particularly to Ontario re the setting up of some 50 to 60 EEG laboratories in this country it was considered high time that standards be set down for accredited electroencephalographers. It was felt that by so doing at this time one could obviate many problems that would arise with regard to training and certification

or accreditation of such specialists. It was felt that this was bound to become of more importance as time went on now that health and insurance schemes for payment of such services are afoot. The establishment of who is such a specialist in EEG will obviate any confusion as to who may charge what for rendering such services as well as serving as a guide to hospital superintendents or other persons seeking to hire EEG's for their laboratories.

It became apparent that neither the Canadian Neurological nor the Canadian Psychiatric Association had any authority or right to draw up any list of names who they considered adequately trained unless they first set standards of training and examination. The more this was gone into the more it became apparent that there was no authoritative body in Canada who could so decide unless it was the Royal College.

As a result of our discussion it became apparent that there ought to be three ways or routes by which one could become a certified EEG. It was felt first and foremost that such a person should first have his M.D. degree following which he might arrive at examination after completing any one of the three training schedules outlined below:

1. It was felt that any man going up for his Fellowship in Neurology or Psychiatry ought also to be able to write his Certificate in EEG following one year of extra time spent in EEG work. The general feeling was that it should take two years of supervised training in EEG but is was felt that if acceptable to the Royal College one of these years in EEG work could be substituted for and equated with the required one year of basic science preparatory to writing the ordinary Fellowship in Psychiatry or Neurology. This would mean that someone going up for a Fellowship in Neurology or Psychiatry could save one year of training time if the Royal College would equate one year of supervised EEG training as one year of basic science training. In the event that someone already holding a Fellowship wished certification in EEG he would be expected to take the full two years of training in EEG work if his year of basic science had already been put in at something else.

2. It was felt that those coming up for certification in Psychiatry or Neurology would have to have the full two years training in EEG work, one of which would be spent under very close supervision whereas the second year could be spent in EEG practice under less stringent supervision. This would mean that such a person might be expected to be able to pass on the normal or ordinary EEG work but would be expected to refer problem cases to his supervisor for his considered opinion.

3. In the event that one wished to take the direct route to certification in EEG without certification in Psychiatry or Neurology then he would be expected to take five years of post-graduate training, two of which would be in EEG work. His first year would be general internship. He should have one year in psychiatry, neurology, neurosurgery or medicine. A third year would be spent in basic science or clinical investigation, a fourth year in closely supervised EEG training and again a fifth year in EEG practice in an institution where less stringent supervision was required but where problem cases could and would be referred to an accredited supervisor.

It was felt that by means of these three routes anyone interested in EEG, whether it be in conjunction with specialization in Neurology or Psychiatry or in pure EEG work, could arrive at specialist standing provided the Royal College found these standards satisfactory and providing they would undertake the setting up of a responsible examining committee or examinations. Generally speaking, it was felt that examinations should cover such subjects as: neuroanatomy, neuropathology, neurology and psychiatry, the practice and technique of EEG, the

history and literature re EEG, EEG interpretation and electronics. It was felt that by setting such standards we would be obviating a lot of the sources of friction, misunderstanding and variable standards existent in the U.S.A. set-up as well setting a consistently high standard second to none if not superior to anywhere in the world and yet quite compatible with the requirements for certification as specialists in any other branch of medicine.

It was proposed that these standards and suggestions first be put to a vote at the business meetings of the Canadian Psychiatric Association and at the Canadian Neurological Association and if favoured there then they would be forwarded to the Royal College for their consideration. We felt that given the approval of the C.P.A. and the C.N.A., favourable hearing and consideration would be given them by the Royal College in spite of their expressed reluctance to assume the responsibility for setting up of certification examinations for any more specialties. It was also felt that the members present at this meeting could represent a "combined standing committee" on EEG standards in the absence of any other representations put forward by these parent organizations or any change. It was also felt that there was no need for any separate society or committee of electroencephalographers in Canada and that they should continue to align themselves with the C.P.A. or C.N.A. as they are presently doing.

This report is respectfully submitted."

(SGD) J. M. Rae, Chairman,
C.P.A. Committee on
Electroencephalographic
Standards.

Dr. Rae, chairman of the committee, presented his report and moved its adoption. Seconded by Dr. Silverman.

In discussion, Dr. Caunt of British Columbia and Dr. Hirsch of Nova Scotia presented adverse criticism of the report from their respective provincial groups of psychiatrists.

Dr. Stokes said that he was against the report most vehemently—it represented another restriction on human freedom, he said, and he felt the idea behind it had emanated from neurologists who were particularly interested in the remuneration of private practice and who wanted to be able to charge for expert reading of EEG's. Dr. Stokes pointed out that there were no such restrictions in the United States where some of the most accomplished E.E.G. men were non-medical. Dr. Cameron said he shared Dr. Stokes' opinions and deplored another restriction on human freedom. On vote the report was DEFEATED.

* * * * *

Report of the Committee on Fee Charging and Medical Care Plans

"The President appointed this committee to undertake two tasks, (a) to study the problems arising from the traditional medical practise of making no charge for the treatment of medical colleagues and their families; and (b) to continue the study of the provisions for psychiatric treatment under the various pre-paid medical care plans.

An attempt was made to canvass the opinion on these points of representatives of organized psychiatry through correspondence with the regional and provincial psychiatric association. In addition the Chairman attempted to gather a sample of individual opinions from psychiatrists in private practice in various parts of the country.

With reference to the problem of charging medical colleagues a fee for service, the opinions were sharply divided according to whether the psychiatrists were psychoanalytically oriented or not.

For the non-psychoanalytic psychiatrists the consensus was that there should be no difference in the practise by psychiatrists from that of other physicians and that no fee should be charged at any time for personal services. A significant minority of this group held, however, that while no fee should be charged for the initial consultation and for brief psychotherapy up to six interviews or one month's treatment, whichever included the most service, continued therapy beyond this should be charged for, probably on a reduced scale agreed to between the psychiatrist and his patient.

The psychoanalytic group, however, felt that fees must be charged on the ground that treatment was usually prolonged and that the therapist who undertook considerable work on behalf of his doctor patients would otherwise suffer grievously. Furthermore there was the underlying assumption that the patient would not benefit from the psychoanalytic treatment if he were not allowed to involve himself financially in the process.

The committee was not able to reconcile these varying points of view and recommends that this problem now be referred to the council of the Canadian Medical Association for guidance.

With reference to the problem of pre-paid medical plans, the issue was transcended by the announcement in January 1956 by the Federal Government of plans to provide financial support for those Provinces wishing to organize and establish a Hospital Insurance Program. The first announcement of this plan stated that patients suffering from mental illness or tuberculosis would be precluded from coverage on the grounds that treatment in mental and tuberculosis hospitals was generally free of charge or provided at a very nominal statutory rate by the provinces.

Subsequently the Federal Minister of Health announced that patients suffering from mental illness who were being treated in General Hospitals would be covered by this insurance plan, but definitely not those patients who were being treated in mental hospitals.

The committee recommends that the following resolution be considered by the Canadian Psychiatric Association:—

Whereas there has been an unfortunate tendency in present government and private plans for providing insurance for hospital care to exclude the patients suffering from mental illness; and

Whereas this in turn tends to discriminate the psychiatric patient from other medical patients;

And whereas this has tended to effect lower standards of care for the mentally ill;

The Canadian Psychiatric Association goes on record as deploring these tendencies and urges that the psychiatric patient be recognized as a medical patient without exception as to the form of hospitalizaion or diagnosis.

Respectfully submitted,"
J. D. Griffin, M.D.
R. O. Jones, M.D.
A. E. Moll, M.D.

Dr. Griffin, chairman of the committee, presented and moved its adoption. Seconded by Dr. W. C. M. Scott.

Opening discussion on the report, Dr. Stokes said he questioned the wisdom of referring the problem of charging fees to medical colleages to the Canadian Medical Association because of the inability of the CPA to reach agreement. Dr. Stokes moved—

THAT further action by the CPA committee shall be related to the equivalent committee of APA;

THAT the work shall be in conjunction with that committee and that the outcome decided by our own committee.

In seconding the motion Dr. Jones stated he did not believe that this was a problem arising only in psychiatry. CARRIED.

Dr. Griffin then presented the portion of his report concerning prepaid medical plans including a resolution and moved its adoption. Dr. Jones seconded and recommended that the resolution go forward to the Federal Minister of Health, the provincial ministers of health and to the Council of the Canadian Medical Association. CARRIED.

* * * * *

Report of Committee on Relationship of Psychiatrists and Clinical Psychologists

"At the annual meeting of the Association held last June in Toronto a statement prepared by this committee (then chaired by Dr. Baruch Silverman) on the problem of the role of clinical psychologists in psychotherapeutic situations was read and adopted.

The present committee has attempted to canvass all provincial and regional psychiatric associations in order to assess local opinions and feelings about the problem and Silverman statement. Word has been received from the following: Newfoundland, The Maritime Psychiatric Association; Quebec Psychiatric Association; the Ontario Neuropsychiatric Association; the Alberta Psychiatric Association and the B.C. Psychiatric Association. Correspondents indicated essential agreement with the Silverman statement in Newfondland, P.E.I., Nova Scotia, New Brunswick, Quebec and B.C. Alberta felt there was no problem in that province and expressed no opinion, Ontario reserved judgment. Further thought is being given by the Committee to the implications in the Silverman statement of the words "The professional contribution to the diagnosis and treatment of illness by psychologists must be co-ordinated under medical responsibility". Furthermore the exact definition of the word "illness" in the above quotation needs clarification.

Material and information relating to this problem have been gathered from British, French and American sources which are being studied.

The recently enacted bill in New York State establishing Certification of Psychologists is noted with interest. It has been noted that Section 7611 of this act under *Privileged Communications* grants the same protection by the court to the psychologist as to the attorney with reference to communications with their clients. It is believed that this is more protection than is currently granted to the psychiatrist. As far an can be ascertained there is no move on foot in Canada to establish a similar certification here for Psychologists.

A friendly contact has been established with the Canadian Psychological Association but no formal meetings with representatives from this organization have yet been held with reference to this subject.

It is recommended that a French speaking Psychiatrist be added to the Committee.

Respectfully submitted,"
J. D. Griffin, M.D.
C. M. Scott, M.D.
Geo. Davidson, M.D.

Dr. Griffin, chairman of the committee, presented his report and moved its adoption. Seconded by Dr. Mary Jackson. CARRIED.

Editorial Committee

"The Bulletin was published in 1955 through the generous co-operation of the Sisters, Superintendent and printing department of St. Jean de Dieu Hospital, Montreal.

At the last annual general meeting the Editor was authorized to proceed with the development of a scientific quarterly to be known as the Canadian Psychiatric Association Journal. Authorities in various areas in psychiatry were invited to form an Editorial Board. Unanimously they accepted and have been of inestimable help. It is hoped that in future years the editorial board might meet for breakfast or lunch at the time of the annual meeting in order that we can have the benefit of their opinions. During this year they were individually contacted by letter asking for advice.

The number of papers submitted is increasing as the Journal becomes known. We are attempting to give a place in each issue, to at least one review article (in the January number—social psychiatry—the April—chemical theories of psychoses—in the next issue it will be mental deficiency) a paper on original basic research, and a clinical paper.

We are not yet satisfied with the service being offered to our colleagues whose native language is French. Dr. Berthiaume has worked hard to provide resumes and I would like to express a special word of gratitude. His task would be immeasurably simplified if authors would submit a summary for translation of 500/600 words. We would appreciate more papers submitted in French.

An extra 600 copies of the first issue were printed and were sent with a message from the President of the C.P.A. to all medical libraries in the English speaking countries and to all psychiatrists in Canada who were not members of the C.P.A. To date we have received about 40 subscriptions.

Commencing 1st Januray 1956 the board of directors of the C.P.A. appointed a Journal Management Committee consisting of the Editor of the Journal, the Secretary and Treasurer of the C.P.A. to carry out the financial operations of publication of the Journal.

A separate set of books and bank account were opened in the name of the Canadian Psychiatric Association Journal.

This account will be subject to annual audit and the financial statement will be presented to the annual general meetings of the Association in future.

We have obtained the privilege of tax free printing, which saves about $300.00 per year and also second class mailing rights, which saves about $60.00 per year.

As pointed out in the annual report last year, it was anticipated that there would be a sizable deficit the first year because of the slow growth of subscription revenue and the need for extra copies, mailing and introductory literature for complimentary copies.

The board of directors accepted liability for a possible deficit of $600.00 on the first year's operation, to be paid from the Association funds. We are glad to report that in spite of increasing the number of Journal pages by 25% per issue we expect a deficit of only about $300.00.

For the year 1957 it is anticipated that the Journal will cost approximately $3,600.00 to publish.

Anticipated revenue is as follows:

Grant from C.P.A. ($2.00 per member)	$ 800.00
Subscriptions	400.00
Advertising	2400.00

Respectfully submitted,"
F. C. R. Chalke, M.D. Chairman,
Journal Management Committee.

Dr. Chalke, Editor of the Journal, moved the adoption of this report. Seconded by Dr. Caunt. Dr. D. E. Cameron moved an amendment.

THAT expression of appreciation for the Editor's remarkable and outstanding contribution to the Journal be incorporated into the report. CARRIED.

* * * * *

Membership Committee

During the year two letters went forward to all psychiatrists in Canada who are non-members of the Association urging their interest and suggesting they apply for membership. This has been quite fruitful.

At present, using the new list of psychiatrists, there are 760 in Canada 415 of whom are members of C.P.A. making the Association representative of 56.8% of resident psychiatrists. Adding 17 members resident outside of Canada brings the total membership to 432.

The breakdown by province is as follows:

Province	No. of Psychiatrists	C.P.A. Members
Newfoundland	10	9
Prince Edward Island	5	5
Nova Scotia	23	18
New Brunswick	26	18
Quebec	177	88
Ontario	315	160
Manitoba	36	19
Saskatchewan	57	37
Alberta	36	22
British Columbia	75	30
CANADA	760	415
Members outside of Canada		17
Total Membership at June 13, 1956		432
Percentage of psychiatrists in Canada who are members		56.8%

Letters have been written to those members who are in arrears. Some have written expressing their regrets and saying they would rectify this oversight.

It is planned to write to the Director in each province, sending a list of non-members and asking for advice regarding further follow-up on these. This awaits secretarial aid.

The Committee feel that the Association is in a healthy condition so far as membership is concerned. We shall continue our efforts to reach as near 100% representation as possible.

S. R. Montgomery, M.D., Chairman.

In the absence of the committee chairman, Dr. Roberts presented the report and moved its adoption. Seconded by Dr. Lawson. CARRIED.

New Committees

Setting up of Joint CMA–CPA Committee on Mental Health

At its meeting in June 1955 the Council of the Canadian Medical Association set up an independent committee on mental hygiene in lieu of the former subcommittee on mental hygiene of the Public Health Committee. Subsequent to this action the C.M.A. approached the C.P.A. inviting the latter to act as the advisory body to C.M.A. in matters of mental health, such arrangement to supersede the C.M.A. Committee on Mental Hygiene. This proposal was circulated to the Board of Directors who were in favour of such action and the C.M.A. was so informed.

Following this action Dr. D. E. Cameron put forward to the President of C.P.A. a proposal to establish a joint committee of C.M.A. and C.P.A. This proposal resulted from Dr. Cameron's awareness of growing interest in Psychiatry on the part of the medical profession generally, the desire amongst general practitioners for refresher courses, the Richardson proposal during the current session of Parliament that a national mental health survey be undertaken, the rapid development of psychiatric services in general hospitals, and so on. The President had considered Dr. Cameron's proposal and the C.M.A. was informally advised of the desire of C.P.A. to form such a committee.

Moved by Dr. Cameron, seconded by Dr. Hobbs–

> THAT the Canadian Psychiatric Association approves the setting up of a joint committee with the Canadian Medical Association to carry on discussions of matters of joint concern.

In discussion, Dr. Hobbs said the Board of Directors could see nothing but merit in the proposal but the consensus was that C.P.A. should first set up its own committee to clarify its ideas before commencing action with the C.M.A. CARRIED.

The following day the board of directors appointed the following to meet with the C.M.A.

CPA committee as appointed by Chairman–Dr. D. Ewen Cameron, chairman; Dr. Jones and Dr. McKerracher as members.

The Secretary reported that Dr. Stokes had recommended to the President that a committee on rehabilitation of CPA be set up. In discussion Dr. Stokes said that he had been appointed to the National Advisory Committee on Rehabilitation which is concerned with all fields of rehabilitation and is a committee with considerable force behind it. Government funds would be expended in this field and Dr. Stokes was concerned as no general consideration was being given to the psychological aspects of rehabilitation to bring about better social conditions. He felt this was a field of social psychiatry which was being neglected. Dr. Stokes moved–

> THAT a committee on rehabilitation be set up within the CPA

Seconded by Dr. Dancey. Dr. McKerracher said the recommendation has been thoroughly discussed and approved by the Board of Directors. CARRIED.

The board of directors appointed the following to serve on this committee–

Dr. W. E. Boothroyd, chairman. Suggestions for corresponding members–Dr. Handforth and Dr. J. D. Armstrong.

* * * * *

Inspection of Hospitals

At the annual general meeting Dr. McNeel the CPA representative on the APA Central Inspection Board was asked to report.

As Dr. McNeel was not present Dr. Roberts reported that the following recommendation to the Board of Directors had been received from Dr. McNeel—"That the matter of the inspection and accreditation of mental hospitals in Canada by an all-Canadian agency be one of the items to be discussed by the Liaison committee (CMA-CPA) and also that the Executive of the CPA consider how an inspection and accrediation service might be financed." Dr. Roberts moved the adoption of the recommendation; seconded by Dr. Jones. CARRIED.

The following day the board of directors appointed an ad hoc committee under the chairmanship of Dr. McNeel to prepare a document regarding Standards and Accrediation of Canadian Mental Hospitals.

* * * * *

Election of Officers

The Nominating Committee presented its report which was unanimously adopted.

Dr. Jones moved a vote of thanks to the retiring president Dr. McKerracher and congratulated him on his election to the Council of the APA.

The meeting was ADJOURNED at 5.30 p.m.

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Starting salary $5,500.00 after one year of residency training in a Provincial Hospital. The next two years to be served at a Medical School Post Graduate Training Centre. Successful candidates will receive a diploma in Psychiatry from the University attended for Post Graduate Training. Candidates would then be eligible for a salary of $6,858.00 per annum. The 4th year of training will be in an approved Mental Health Division after which candidates are eligible for examination for a specialist's certificate in Psychiatry from the Royal College of Physicians and Surgeons (Canada). Upon certification, Physicians will be eligible for a minimum salary of $7,800.00 per annum.

Further information may be obtained by writing to the Chairman, Civil Service Commission, P.O. Box 1055, Fredericton, New Brunswick, Canada or the Director of Mental Health Services, Department of Health and Social Services, 658 Queen Street, Fredericton, New Brunswick, Canada.

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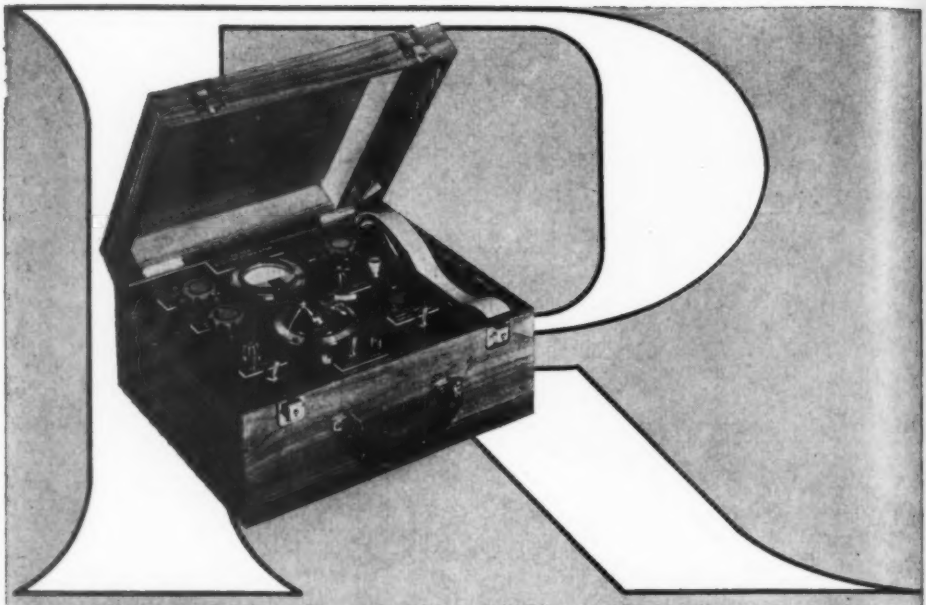

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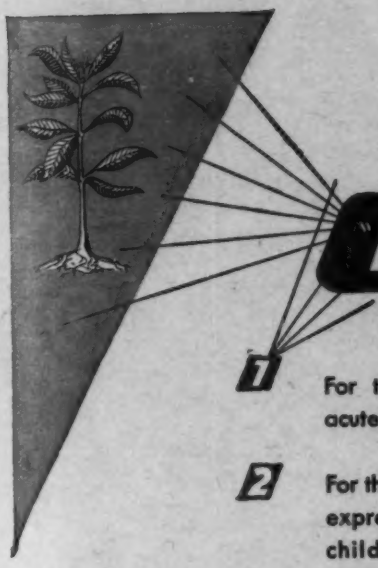

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References:

1. Meier, R., Gross, F., and Tripod, J. (1954) Klin. Wschr. 32, 445.

2. Stier, C. (1955) Ther. d. Gegenw. 94.

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